Provider Enrollment and Ongoing Responsibilities

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

Topic #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.

In-state emergency providers and out-of-state providers who dispense covered outpatient drugs will be assigned a professional dispensing fee reimbursement rate of $10.51.

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*.

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 website.

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 #22257

Providers Have 35 Days to Report a Change in Ownership

Medicaid-enrolled providers are required to notify ForwardHealth of a change in ownership within 35 calendar days after the effective date of the change, in accordance with the Centers for Medicare & Medicaid Services Final Rule 42 C.F.R. § 455.104 (c)(1)(iv).

Failure to report a change in ownership within 35 calendar days may result in denial of payment, per 42 C.F.R. § 455.104(e).

Note: For demographic changes that do not constitute a change in ownership, providers should update their current information using the demographic maintenance tool.

Written Notification and a New Enrollment Application Are Required

Any time a change in ownership occurs, providers are required to do **one** of the following:

- Mail a change in ownership notification to ForwardHealth. After mailing the notification, providers are required to complete a new Medicaid provider enrollment application on the Portal.
- Upload a change in ownership notification as an attachment when completing a new Medicaid provider enrollment application on the Portal.

ForwardHealth must receive the change in ownership notification, which must include the affected provider number (NPI (National Provider Identifier) or provider ID), within 35 calendar days **after** the effective date of the change in ownership.

Providers will receive written notification of their new Medicaid enrollment effective date in the mail once their provider file is updated with the change in ownership.

Special Requirements for Specific Provider Types

The following provider types require Medicare enrollment and/or Wisconsin DQA (Division of Quality Assurance) certification with current provider information before submitting a Medicaid enrollment change in ownership:

- Ambulatory surgery centers
- CHCs (Community Health Centers)
- ESRD (End Stage Renal Disease) services providers
- Home health agencies
- Hospice providers
- Hospitals (inpatient and outpatient)
- Nursing homes
- Outpatient rehabilitation facilities
- Rehabilitation agencies
- RHCs (Rural Health Clinics)
- Tribal FQHCs (Federally Qualified Health Centers)

Events That ForwardHealth Considers a Change in Ownership

ForwardHealth defines a change in ownership as an event where a different party purchases (buys out) or otherwise obtains ownership or effective control over a practice or facility.

The following events are considered a change in ownership and require the completion of a new provider enrollment application:

- Change from one type of business structure to another type of business structure. Business structures include the following:
  - Sole proprietorships
  - Corporations
  - Partnerships
  - Limited Liability Companies
- Change of name and TIN (Tax Identification Number) associated with the provider's submitted enrollment application (for example, EIN (Employer Identification Number))
- Change (addition or removal) of names identified as owners of the provider

Examples of a Change in Ownership

Examples of a change in ownership include the following:

- A sole proprietorship transfers title and property to another party.
- Two or more corporate clinics or centers consolidate, and a new corporate entity is created.
- There is an addition, removal, or substitution of a partner in a partnership.
- An incorporated entity merges with another incorporated entity.
- An unincorporated entity (sole proprietorship or partnership) becomes incorporated.

End Date of Previous Owner's Enrollment

The end date of the previous owner's enrollment will be one day prior to the effective date for the change in ownership. When the Wisconsin DHS (Department of Health Services) is notified of a change in ownership, the original owner's enrollment will automatically be end-dated.

Repayment Following a Change in Ownership

Medicaid-enrolled providers who sell or otherwise transfer their business or business assets are required to repay ForwardHealth for any erroneous payments or overpayments made to them. If the previous owner does not repay ForwardHealth for any erroneous payments or overpayments, the new owner's application will be denied.

If necessary, ForwardHealth will hold responsible for repayment the provider to whom a transfer of ownership is made prior to the final transfer of ownership. The provider acquiring the business is responsible for contacting ForwardHealth to ascertain if they are liable under this provision.

The provider acquiring the business is responsible for full repayment within 30 days after receiving such a notice from ForwardHealth.

Providers may send inquiries about the determination of any pending liability to the following address:

Office of the Inspector General
PO Box 309
Madison WI 53701-0309

ForwardHealth has the authority to enforce these provisions within four years following the transfer of a business or business assets. Refer to Wis. Stat. § 49.45(21) for complete information.

Automatic Recoupment Following a Change in Ownership

ForwardHealth will automatically recover payments made to providers whose enrollment has ended in the ForwardHealth system due to a change in ownership. This automatic recoupment for previous owners occurs about 45 days after DHS is notified of the change in ownership. The recoupment will apply to all claims processed with DOS (Dates of Service) after the provider's new end date.

New Prior Authorization Requests Must Be Submitted After a Change in Ownership

Medicaid-enrolled providers are required to submit new PA (Prior Authorization) requests when there is a change in billing providers. New PA requests must be submitted with the new billing provider's name and billing provider number. The expiration date of the new PA request will remain the same as the original PA request.

The provider is required to send the following to ForwardHealth with the new PA request:

- A copy of the original PA request, if possible
- The new PA request, including the required attachments and supporting documentation indicating the new billing provider's name, address, and billing provider number
- A letter requesting to enddate the original PA request (may be a photocopy), which should include the following information:
  - The previous billing provider's name and billing provider number, if known
  - The new billing provider's name and billing provider number
  - The reason for the change of billing provider (The new billing provider may want to verify with the member that the services from the previous billing provider have ended. The new billing provider may include this verification in the letter).
  - The requested effective date of the change

Submitting Claims After a Change in Ownership

The provider acquiring the business may submit claims with DOS on and after the change in ownership effective date.

Additional information on submission of timely filing requests or adjustment reconsideration requests is available.

How to Bill for a Hospital Stay That Spans a Change in Ownership

When a change in hospital ownership occurs, use the NPI that is current on the date of discharge. For example: A change in ownership occurs on July 1. A patient stay has DOS from June 26 to July 2. The hospital submits the claim using the NPI effective July 1.

How to Bill for a Nursing Home Stay That Spans a Change in Ownership

When a change in nursing home ownership occurs, use the NPI that is current on the date of discharge. For example: A change in ownership occurs on July 1. A nursing home patient stay has DOS from June 26 to July 2. The nursing home submits the claim using the NPI effective July 1.

For Further Questions

Providers with questions about changes in ownership may call Provider Services.

Topic #14317

Terminology to Know for Provider Enrollment

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 C.F.R. s. 455.101 for more information.

New Terminology	Definition
Agent	Any person who has been delegated the authority to obligate or act on behalf of a provider.
Disclosing entity	A Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.
Federal health care programs	Federal health care programs include Medicare, Medicaid, Title XX, and Title XXI.
Other disclosing agent	Any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVII, or XX of the Act. This includes: - Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or HMO that participates in Medicare (Title XVIII) - Any Medicare intermediary or carrier - Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or XX of the Act
Indirect ownership	An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership in the disclosing entity.

Managing employee	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.
Ownership interest	The possession of equity in the capital, the stock, or the profits of the disclosing entity.
Person with an ownership or control interest	A person or corporation for which one or more of the following applies: - Has an ownership interest totaling 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	- An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or, - An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.
Re-enrollment	Re-enrollment of a provider whose Medicaid enrollment has ended for any reason other than sanctions or failure to revalidate may be re-enrolled as long as all licensure and enrollment requirements are met. Providers should note that when they re-enroll, application fees and screening activities may apply. Re-enrollment was formerly known as re-instate.
Revalidation	All enrolled providers are required to revalidate their enrollment information every three years to continue their participation with Wisconsin Medicaid. Revalidation was formerly known as recertification.

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

Topic #1206

Tribal Federally Qualified Health Centers

A tribal FQHC (Federally Qualified Health Center) is an outpatient health program or facility operated by a tribe or tribal organization receiving funds under the Indian Self-Determination Act (Public Law 93-638).

Physician, Dental, and Chiropractic Services

Tribal FQHCs may provide the following services and submit claims for these services:

- Physician
- Dental (including dental hygienists)
- Chiropractic

The Physician, Dental, and Chiropractic service areas have information regarding covered services, PA (prior authorization) guidelines, and billing instructions.

Other Services

Tribal FQHCs may also be enrolled as the following provider types:

- Ambulance
- Case management
- Community support programs
- Comprehensive Community Support
- 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)
- Pharmacy
- PNCC (prenatal care coordination)
- Rehabilitation agency
- RHC (rural health clinic)
- SMV (specialized medical vehicle)

Refer to the corresponding service areas of the listed provider types for information regarding covered services, PA guidelines, and billing instructions.

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 5 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 C.F.R. 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 Wisconsin 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 of 1990, any provider that operates an existing public accommodation has four specific requirements:

1. Remove barriers to make their 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 ensure contracted agencies are qualified to provide services, meet all ForwardHealth and program requirements, and maintain records in accordance with the requirements for the provision of services.

Medicaid requirements do not relieve contracted agencies of their own regulatory requirements. Contracted agencies are required to continue to meet their own regulatory requirements, in addition 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 their 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 emailing Lisa.Imhof@dhs.wisconsin.gov.

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 C.F.R. Parts 430-498 and Parts 1000-1008 (Public Health)
- Wisconsin Law and Regulation:
  - Law — Wis. Stat. §§ 49.43-49.499, 49.665, and 49.473
  - Regulation — Wis. Admin. Code chs. 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 Wisconsin DHS (Department of Health Services). Within DHS, DMS (Division of Medicaid Services) 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 855-699-6289. Refer to the RAC website for additional information regarding HMS RAC activities.

Topic #13277

Reporting Suspected Waste, Fraud, and Abuse

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

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

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

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

Reporting Suspected Fraud and Abuse

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

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

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

The following information is helpful when reporting fraud and abuse:

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

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

Documentation

Topic #6277

1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than $600.00, 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 Wisconsin DHS (Department of Health Services) has the right to inspect, review, audit, and reproduce provider records pursuant to Wis. Admin. Code § DHS 106.02(9)(e). 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 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 their 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 C.F.R. Parts 160 and 164 and § 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 U.S. HHS (Department of Health and Human Services). According to 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) website.

For more information regarding securing PHI, providers may refer to Health Information Privacy on the HHS website.

Wisconsin Confidentiality Laws

Wis. Stat. § 134.97 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.

Wis. Stat. § 146.836 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 Wis. Stat. § 134.97(1)(e), 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

Wis. Stat.§§ 134.97 and 134.98, 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, Wis. Stat. § 34.97(4) 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 § 13410(d) of the HITECH Act, which amends 42 USC § 1320d-5, and Wis. Stat. §§ 134.97(3), (4) and 146.84.

Topic #201

Financial Records

According to Wis. Admin. Code § DHS 106.02(9)(c), 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 Wis. Admin. Code § DHS (Department of Health Services) 106.02(9)(b), 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 Wis. Stat. § 146.83, 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 Wis. Stat. § 146.81(4), 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 Wisconsin DHS (Department of Health Services) adjusts the amounts a provider may charge for providing copies of a member's health care records yearly per Wis. Stat. § 146.83(3f)(c).

Topic #16157

Policy Requirements for Use of Electronic Signatures on Electronic Health Records

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

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

Electronic Signature Definition

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

Some examples include:

- Typed name (performer may type their complete name)
- Number (performer may type a number unique to them)
- Initials (performer may type initials unique to them)

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

Benefits of Using Electronic Signatures

The use of electronic signatures will allow providers to:

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

Electronic Signature Requirements

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

General Requirements

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

- The electronic signature must be under the sole control of the rendering provider. Only the rendering provider or designee has the authority to use the rendering provider's electronic signature. Providers are required to maintain documentation that shows the electronic signature that belongs to each rendering provider if a numbering or initial system is used (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 Wisconsin DHS (Department of Health Services) recommends the provider conduct an annual review of policies and procedures with

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

Electronic Health Record Signature Requirements

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

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

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 Wis. Admin. Code § DHS 106.02(9)(a). 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 Wis. Admin. Code § DHS 106.02(9)(d), 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 Wisconsin DHS (Department of Health Services) periodically reviews provider records. 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) § 4311, a dual eligible has the right to request and receive an itemized statement from their 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 Wisconsin 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.

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 Wis. Admin. Code § DHS 106.05.

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 Wisconsin DHS (Department of Health Services) action or inaction for which due process is

required under Wis. Stat. ch. 227, may request a hearing by writing to the DHA (Division of Hearings and Appeals).

A provider who wishes to contest the DMS (Division of Medicaid Services)'s notice of intent to recover payment (e.g., to recoup for overpayments discovered in an audit by DMS) 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 Wis. Admin. Code ch. DHS 106 for detailed instructions on how to file an appeal.

If a timely request for a hearing is not received, 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 DMS (Division of Medicaid Services) will consider applications for, a discretionary waiver or variance of certain rules in Wis. Admin. Code chs. DHS 102, 103, 104, 105, 107, and 108. Rules that are not considered for a discretionary waiver or variance are included in Wis. Admin. Code § DHS 106.13.

Waivers and variances are not available to permit coverage of services that are either expressly identified as noncovered or are not expressly mentioned in Wis. Admin. Code ch. DHS 107.

Requirements

A request for a waiver or variance may be made at any time; however, all applications must be made in writing to the DMS. 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 DMS may also require additional information from the provider or the member prior to acting on the request.

Application

The DMS 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 Medicaid Services
Waivers and Variances
PO Box 309
Madison WI 53701-0309

Sanctions

Topic #211

Intermediate Sanctions

According to Wis. Admin. Code § DHS 106.08(3), the Wisconsin DHS (Department of Health Services) may impose intermediate sanctions on providers who violate certain requirements. Common examples of sanctions that 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, DHS will issue a written notice to the provider in accordance with Wis. Admin. Code § DHS 106.12.

Any sanction imposed by DHS may be appealed by the provider under Wis. Admin. Code § DHS 106.12. Providers may appeal a sanction by writing to the DHA (Division of Hearings and Appeals).

Topic #212

Involuntary Termination

The Wisconsin DHS (Department of Health Services) may suspend or terminate the Medicaid enrollment of any provider according to Wis. Admin. Code § DHS 106.06.

The suspension or termination may occur if both of the following apply:

- 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 DHS. Refer to Wis. Admin. Code § DHS 106.07 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 § 1320a-7b(d) or Wis. Stat. § 49.49(3m).

There may be narrow exceptions on when providers may collect payment from members.

Topic #214

Withholding Payments

The Wisconsin 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, 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.

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.

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 #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)
- BBG (brand before generic) drugs that require PA
- BMN (brand medically necessary) drugs that require PA
- Diagnosis-restricted drugs
- Age-restricted drugs
- Quantity limits

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 (for example, 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.

Most drugs and drug classes included on the PDL are covered fee-for-service by BadgerCare Plus, Wisconsin Medicaid, and SeniorCare, but certain drugs may have restrictions (for example, diagnosis, quantity limits, age limits). Prescribers are encouraged to write prescriptions for preferred drugs if medically appropriate. Prescribers are encouraged to try more than one preferred drug, if medically appropriate for the member, before prescribing a non-preferred drug. Non-preferred drugs may be covered with an approved PA request. Most preferred drugs do not require PA, except in designated classes identified on the Preferred Drug List Quick Reference.

Prescriber Responsibilities for Non-Preferred Drugs

If a member is enrolled in BadgerCare Plus, Wisconsin 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 from the same drug class.

If a non-preferred drug or a preferred drug that requires clinical PA is medically necessary for a member, the prescriber must complete, sign, and date the appropriate PA form for the drug. When completing the PA form, prescribers are required to provide a handwritten signature on the form.

The PA form must be sent to the pharmacy where the prescription will be filled. The PA form may be sent to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

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

Diagnosis-Restricted Drugs

Prescribers are required to indicate a diagnosis on prescriptions for all drugs that are identified by ForwardHealth as 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 CMS (Centers for Medicare & Medicaid Services). BadgerCare Plus, Wisconsin 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 BadgerCare Plus, Wisconsin 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 (07/2016)) as it pertains to the drug being requested.

Included with the PA request, 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 (04/2017)) form indicating the actual NDC (National Drug Code) of the drug with the Pharmacy Special Handling Request (F-13074 (04/2014)) 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.

Prospective Drug Utilization Review System

The federal OBRA (Omnibus Budget Reconciliation Act) of 1990 (42 C.F.R. 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 prospective DUR system checks the member's entire pharmacy paid claims history regardless of where the drug was dispensed or by whom it was prescribed.

Diagnoses from medical claims are used to build a disease or pregnancy 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 pharmacy receives a prospective DUR alert, a DUR segment 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.

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 copays
- Requiring fewer trips to the pharmacy
- Allowing the member to obtain a larger quantity of generic, maintenance drugs for chronic conditions (for example, 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 (for example, 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 (that is, PRN (pro re nata)) 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 Medicaid-enrolled retail pharmacies to deliver prescriptions to members via the mail. 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 that have not signed the rebate agreement
- Drugs to treat the condition of ED (erectile dysfunction). Examples of noncovered drugs for ED are tadalafil (Cialis) and sildenafil (Viagra).

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 Wisconsin Medicaid, SeniorCare does not cover OTC drugs other than insulin. SeniorCare also covers vaccines that are approved by the CDC (Centers for Disease Control and Prevention) ACIP (Advisory Committee on Immunization Practices) for people age 65 and older and are administered through a pharmacy.

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 Numbers

Topic #1891

Group Billing Numbers

For the purposes of this Online Handbook topic, FQHC (federally qualified health center) refers to Tribal and Out-of-State FQHCs. This topic does not apply to Community Health Centers subject to PPS (Prospective Payment System) reimbursement.

Claims that are submitted under an FQHC 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 website. The federal CMS (Centers for Medicare and Medicaid Services) website 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

For the purposes of this Online Handbook topic, FQHC (federally qualified health center) refers to Tribal and Out-of-State FQHCs. This document does not apply to Community Health Centers subject to PPS (Prospective Payment System) reimbursement.

FQHCs 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 website.

Covered and Noncovered Services

2

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Covered and Noncovered Services:Codes

Topic #1889

Allowable Codes

For the purposes of this Online Handbook topic, FQHC (federally qualified health center) refers to Tribal and Out-of-State FQHCs. This topic does not apply to Community Health Centers subject to PPS (Prospective Payment System) reimbursement.

FQHCs 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

Cellular/Tissue-Based Products

The following table lists allowable procedure codes, corresponding application codes, and related ICD (International Classification of Diseases) 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. More information regarding ForwardHealth's coverage policy for CTPs is available.

HCPCS Code	Description	Covered Conditions	CPT Application Code	Allowable ICD Diagnosis Code (s)	Description

Q4101	Apligraf, per square centimeter	**Venous leg ulcers**	**15271–15278**	I83.001–I83.029	Varicose veins of lower extremity with ulcer
				I83.201–I83.229	Varicose veins of lower extremity with ulcer and inflammation
				I87.2	Venous insufficiency (chronic) (peripheral)
				I70.231*–I70.25*	Atherosclerosis of native arteries of leg with ulceration
				I70.331*–I70.749*	Atherosclerosis of bypass graft(s) of leg with ulceration
				L97.201*–L97.529*	Non-pressure chronic ulcer
		Full-thickness neuropathic diabetic foot ulcers	**15275–15278**	E08.621, E09.621, E10.621, E11.621, E13.621	Diabetes mellitus with foot ulcer
				E08.622, E09.622, E10.622, E11.622, E13.622	Diabetes mellitus with other skin ulcer
				L97.301**–L97.529**	Non-pressure chronic ulcer of ankle, heel, or foot
Q4106	Dermagraft, per square centimeter	**Full-thickness neuropathic diabetic foot ulcers**	**15275–15278**	E08.621, E09.621, E10.621, E11.621, E13.621	Diabetes mellitus with foot ulcer
				E08.622, E09.622, E10.622, E11.622, E13.622	Diabetes mellitus with other skin ulcer
				L97.301**–L97.529**	Non-pressure chronic ulcer of ankle, heel, or foot

Q4116	Alloderm, per square centimeter	**Breast reconstructive surgery**	**15271–15274, 15777**	C50.011–C50.019	Malignant neoplasm of nipple and areola, female
				C50.111–C50.119	Malignant neoplasm of central portion of breast, female
				C50.211–C50.219	Malignant neoplasm of upper-inner quadrant of breast, female
				C50.311–C50.319	Malignant neoplasm of lower-inner quadrant of breast, female
				C50.411–C50.419	Malignant neoplasm of upper-outer quadrant of breast, female
				C50.511–C50.519	Malignant neoplasm of lower-outer quadrant of breast, female
				C50.611–C50.619	Malignant neoplasm of axillary tail of breast, female
				C50.811–C50.819	Malignant neoplasm of overlapping sites of breast, female
				C50.911–C50.919	Malignant neoplasm of breast of unspecified site, female
				C50.021–C50.029	Malignant neoplasm of nipple and areola, male
				C50.121–C50.129	Malignant neoplasm of central portion of breast, male
				C50.221–C50.229	Malignant neoplasm of upper-inner quadrant of breast, male
				C50.321–C50.329	Malignant neoplasm of lower-inner quadrant of breast, male
				C50.421–C50.429	Malignant neoplasm of upper-outer quadrant of

					breast, male
				C50.521–C50.529	Malignant neoplasm of lower-outer quadrant of breast, male
				C50.621–C50.629	Malignant neoplasm of axillary tail of breast, male
				C50.821–C50.829	Malignant neoplasm of overlapping sites of breast, male
				C50.921–C50.929	Malignant neoplasm of breast of unspecified site, male
				D05.00–D05.02	Lobular carcinoma in situ of breast
				D05.10–D05.12	Intraductal carcinoma in situ of breast
				D05.80–D05.82	Other specified type of carcinoma in situ of breast
				D05.90–D05.92	Unspecified type of carcinoma in situ of breast
				Z85.3	Personal history of malignant neoplasm of breast
				Z90.10–Z90.13	Acquired absence of breast and nipple
Q4132	Grafix core and GrafixPL core, per square centimeter	**Venous leg ulcers**	**15271–15278**	I83.001–I83.029	Varicose veins of lower extremity with ulcer
				I83.201–I83.229	Varicose veins of lower extremity with ulcer and inflammation
				I87.2	Venous insufficiency (chronic) (peripheral)
				I70.231*–I70.25*	Atherosclerosis of native arteries of leg with ulceration
				I70.331*–I70.749*	Atherosclerosis of bypass graft(s) of leg with ulceration
				L97.201*–	Non-pressure chronic ulcer

				L97.529*	
		Full-thickness neuropathic diabetic foot ulcers	**15275–15278**	E08.621, E09.621, E10.621, E11.621, E13.621	Diabetes mellitus with foot ulcer
				E08.622, E09.622, E10.622, E11.622, E13.622	Diabetes mellitus with other skin ulcer
				L97.301**–L97.529**	Non-pressure chronic ulcer of ankle, heel, or foot
Q4133	Grafix prime and GrafixPL prime, per square centimeter	**Venous leg ulcers**	**15271–15278**	I83.001–I83.029	Varicose veins of lower extremity with ulcer
				I83.201–I83.229	Varicose veins of lower extremity with ulcer and inflammation
				I87.2	Venous insufficiency (chronic) (peripheral)
				I70.231*–I70.25*	Atherosclerosis of native arteries of leg with ulceration
				I70.331*–I70.749*	Atherosclerosis of bypass graft(s) of leg with ulceration
				L97.201*–L97.529*	Non-pressure chronic ulcer
		Full-thickness neuropathic diabetic foot ulcers	**15275–15278**	E08.621, E09.621, E10.621, E11.621, E13.621	Diabetes mellitus with foot ulcer
				E08.622, E09.622, E10.622, E11.622, E13.622	Diabetes mellitus with other skin ulcer
				L97.301**–	Non-pressure chronic ulcer

				L97.529**	of ankle, heel, or foot
Q4186	Epifix, per square centimeter	**Venous leg ulcers**	**15271–15278**	I83.001–I83.029	Varicose veins of lower extremity with ulcer
				I83.201–I83.229	Varicose veins of lower extremity with ulcer and inflammation
				I87.2	Venous insufficiency (chronic) (peripheral)
				I70.231*–I70.25*	Atherosclerosis of native arteries of leg with ulceration
				I70.331*–I70.749*	Atherosclerosis of bypass graft(s) of leg with ulceration
				L97.201*–L97.529*	Non-pressure chronic ulcer
		Full-thickness neuropathic diabetic foot ulcers	**15275–15278**	E08.621, E09.621, E10.621, E11.621, E13.621	Diabetes mellitus with foot ulcer
				E08.622, E09.622, E10.622, E11.622, E13.622	Diabetes mellitus with other skin ulcer
				L97.301**–L97.529**	Non-pressure chronic ulcer of ankle, heel, or foot
Q4187	Epicord, per square centimeter	**Venous leg ulcers**	**15271–15278**	I83.001–I83.029	Varicose veins of lower extremity with ulcer
				I83.201–I83.229	Varicose veins of lower extremity with ulcer and inflammation
				I87.2	Venous insufficiency (chronic) (peripheral)
				I70.231*–I70.25*	Atherosclerosis of native arteries of leg with ulceration
				I70.331*–	Atherosclerosis of bypass

				I70.749*	graft(s) of leg with ulceration
				L97.201*–L97.529*	Non-pressure chronic ulcer
		Full-thickness neuropathic diabetic foot ulcers	**15275–15278**	E08.621, E09.621, E10.621, E11.621, E13.621	Diabetes mellitus with foot ulcer
				E08.622, E09.622, E10.622, E11.622, E13.622	Diabetes mellitus with other skin ulcer
				L97.301**–L97.529**	Non-pressure chronic ulcer of ankle, heel, or foot

* The ICD diagnosis code must be billed with ICD code I87.2 (Venous insufficiency [chronic] [peripheral]) as the primary diagnosis.

** The ICD code must be billed with an ICD diagnosis code for diabetic ulcers (E08.621, E08.622, E09.621, E09.622, E10.621, E10.622, E11.621, E11.622, E13.622, E13.621, E13.622). Note that categories E08 and E09 have a code first rule which states the underlying condition precipitating the diabetes must be coded first.

Topic #18198

Sleep Medicine Testing

The following tables contain lists of procedure codes that are covered by Wisconsin Medicaid and BadgerCare Plus for sleep studies and polysomnography.

Note: The information included in the tables is subject to change. For the most current information, refer to the maximum allowable fee schedule.

Allowable Facility-Based Sleep Studies and Polysomnography Procedure Codes

CPT (Current Procedural Terminology) Procedure Code	Description
95805 Multiple Sleep Latency Test/Maintenance of Wakefulness Test	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness
95806 Unattended Sleep Study—Type III	Sleep study, unattended, simultaneous recording of heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)

95807 In-Lab Sleep Study (PSG)	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist
95808 In-Lab Sleep Study (PSG)	Polysomnography; any age, sleep staging with 1–3 additional parameters of sleep, attended by a technologist
95810 In-Lab Sleep Study (PSG)	age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95811 In-Lab Sleep Study (PSG)	age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist
95782 In-Lab Sleep Study (PSG)	younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95783 In-Lab Sleep Study (PSG)	younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist

Allowable Home-Based Sleep Studies Procedure Codes

HCPCS (Healthcare Common Procedure Coding System) Procedure Code	Description
G0398 Home Sleep Study—Type II	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation
G0399 Home Sleep Study—Type III	Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation

Topic #643

Unlisted Procedure Codes

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

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

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

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

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

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

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

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

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

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

Unlisted Codes That Do Not Require Prior Authorization

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

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

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

How to Submit Claims and Related Documentation

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

- If submitting on paper using the 1500 Health Insurance Claim Form ((02/12)), the provider may do either of the following:
  - Include supporting information/description in Item Number 19 of the claim form.
  - Include supporting documentation on a separate paper attachment. This option should be used if Item Number 19 on the 1500 Health Insurance Claim Form does not allow enough space for the description or when billing multiple unlisted procedure codes. Providers should indicate "See Attachment" in Item Number 19 of the claim form and send the supporting documentation along with the claim form.

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

Topic #830

Valid Codes Required on Claims

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

Code Validity

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

Code Specificity for Diagnosis

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

Covered Services and Requirements

Topic #23077

Beyfortus Covered Through the Vaccines for Children Program

Beyfortus (nirsevimab), a monoclonal antibody, is used for the prevention of lower respiratory tract disease caused by RSV (respiratory syncytial virus) in infants or children.

The CDC (Centers for Disease Control and Prevention)'s ACIP (Advisory Committee on Immunization Practices) recommends the routine use of Beyfortus for the prevention of RSV for newborns and infants younger than 8 months of age born during or entering their first RSV season. The ACIP also recommends the routine use of Beyfortus for children aged 8 to 19 months who are at increased risk of severe RSV, which includes Alaska Native and American Indian children, as defined by the Indian Health Care Improvement Act, who are entering their second RSV season.

Beyfortus Supplied Through the Vaccines for Children Program

The federal VFC (Vaccines for Children) Program was created to provide vaccines to eligible children through enrolled public and private providers. The VFC Program is part of a national approach to improving immunization services and levels.

Although not a vaccine, the ACIP voted to include Beyfortus in the VFC Program.

ForwardHealth covers Beyfortus consistent with current policies for immunization services. Therefore, providers are required to obtain Beyfortus for children from the VFC supply. ForwardHealth reimburses only an administration code for Beyfortus supplied through the VFC Program.

Providers may refer to the Wisconsin Immunization Program for contact information about enrolling in the VFC Program.

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; physician or other qualified health care professional [office] provided equipment, 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; analysis, 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 on the interactive maximum allowable fee schedule.

Note: Procedure code 99091 (Collection and interpretation of physiologic data [eg, ECG, blood pressure, glucose monitoring] digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation [when applicable] requiring a minimum of 30 minutes of time, each 30 days) 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 an optimal insulin regimen for a member 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 devices, transmitters, and sensors are covered in certain circumstances. PA is required for coverage of monitoring devices and transmitters, but it is not required for sensors.

Allowable Procedure Codes

The following HCPCS (Healthcare Common Procedure Coding System) procedure codes are allowable for personal continuous

glucose monitoring devices and accessories:

- A9276 (Sensor; invasive [e.g., subcutaneous], disposable, for use with interstitial continuous glucose monitoring system, one unit = 1 day supply)
- A9277 (Transmitter; external, for use with interstitial continuous glucose monitoring system)
- A9278 (Receiver [monitor]; external, for use with interstitial continuous glucose monitoring system)

Topic #44

Definition of Covered Services

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

Topic #22917

Interpretive Services

ForwardHealth reimburses interpretive services provided to BadgerCare Plus and Medicaid members who are deaf or hard of hearing or who have LEP (limited English proficiency). A member with LEP is someone who does not speak English as their primary language and who has a limited ability to read, speak, write, or understand English.

Interpretive services are defined as the provision of spoken or signed language communication by an interpreter to convey a message from the language of the original speaker into the language of the listener in real time (synchronous) with the member present. This task requires the language interpreter to reflect both the tone and the meaning of the message.

Only services provided by interpreters of the spoken word or sign language will be covered with the HCPCS (Healthcare Common Procedure Coding System) procedure code T1013 (Sign language or oral interpretive services, per 15 minutes). Translation services for written language are not reimbursable with T1013, including services provided by professionals trained to interpret written text.

Covered Interpretive Services

ForwardHealth covers interpretive services for deaf or hard of hearing members or members with LEP when the interpretive service and the medical service are provided to the member on the same DOS (date of service) and during the same time as the medical service. A Medicaid-enrolled provider must submit for interpretive services on the same claim as the medical service, and the DOS they are provided to the member must match. Interpretive services cannot be billed by HMOs and MCOs (managed care organizations). Providers should follow CPT (Current Procedural Terminology) and HCPCS coding guidance to appropriately document and report procedure codes related to interpretive and medical services on the applicable claim form. Time billed for interpretive services should reflect time spent providing interpretation to the member. At least three people must be present for the services to be covered: the provider, the member, and the interpreter.

Interpreters may provide services either in-person or via telehealth. Services provided via telehealth must be functionally equivalent to an in-person visit, meaning that the transmission of information must be of sufficient quality as to be the same level of service as an in-person visit. Transmission of voices, images, data, or video must be clear and understandable. Both the distant and originating sites must have the requisite equipment and staffing necessary to provide the telehealth service.

Billing time for documentation of interpretive services will be considered part of the service performed. BadgerCare Plus and Wisconsin Medicaid have adopted the federal "Documentation Guidelines for Evaluation and Management Services" (CMS (Centers for Medicare & Medicaid Services) 2021 and 2023) in combination with BadgerCare Plus and Medicaid policy for E&M (evaluation and management) Services.

Most Medicaid-enrolled providers, including border-status or out-of-state providers, are able to submit claims for interpretive services.

Standard ForwardHealth policy applies to the reimbursement for interpretive services for out-of-state providers, including PA (prior authorization) requirements.

Interpretive Services Provided Via Telehealth for Out-of-State Providers

ForwardHealth requirements for services provided via telehealth by out-of-state providers are the same as the ForwardHealth policy for services provided in-person by out-of-state providers. Requirements for out-of-state providers for interpretive services are the same whether the service is provided via telehealth or in-person. Out-of-state providers who are not enrolled as either border-status or telehealth-only border-status providers are required to obtain PA before providing services via telehealth to BadgerCare Plus or Medicaid members. The PA would indicate that interpretive services are needed.

Documentation

While not required for submitting a claim for interpretive services, providers must include the following information in the member's file:

- The interpreter's name and/or company
- The date and time of interpretation
- The duration of the interpretive service (time in and time out or total duration)
- The amount submitted by the medical provider for interpretive services reimbursement
- The type of interpretive service provided (foreign language or sign language)
- The type of covered service(s) the provider is billing for

Third-Party Vendors and In-House Interpreters

Providers may be reimbursed for the use of third-party vendors or in-house interpreters supplying interpretive services.

Providers are reminded that HIPAA (Health Insurance Portability and Accountability Act of 1996) confidentiality requirements apply to interpretive services. When a covered entity or provider utilizes interpretive services that involve PHI (protected health information), the entity or provider will need to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to PHI confidentiality, integrity, and availability. Each entity or provider must assess what are reasonable and appropriate measures for their situation.

Limitations

There are no limitations for how often members may utilize interpretive services when the interpretive service is tied to another billable medical service for the member for the same DOS.

Claims Submission

To receive reimbursement, providers may bill for interpretive services on one of the following claim forms:

- 1500 Health Insurance Claim Form ((02/12)) (for dental, professional, and professional crossover claims)
- Institutional UB-04 (CMS 1450) claim form (for outpatient crossover claims and home health/personal care claims)

Noncovered Services

The following will not be eligible for reimbursement with procedure code T1013:

- Interpretive services provided in conjunction with a noncovered, non-reimbursable, or excluded service
- Interpretive services provided by the member's family member, such as a parent, spouse, sibling, or child
- The interpreter's waiting time and transportation costs, including travel time and mileage reimbursement, for interpreters to get to or from appointments
- The technology and equipment needed to conduct interpretive services
- Interpretive services provided directly by the HMOs and MCOs are not billable to ForwardHealth for reimbursement via procedure code T1013

Cancellations or No Shows

Providers cannot submit a claim for interpretive services if an appointment is cancelled, the member or the interpreter is a no-show (is not present), or the interpreter is unable to perform the interpretation needed to complete the appointment successfully.

Procedure Code and Modifiers

Providers must submit claims for interpretive services and the medical service provided to the member on separate details on the same claim.

Procedure code T1013 is a time-based code, with 15-minute increments. Rounding up to the 15-minute mark is allowable if at least eight minutes of interpretation were provided.

Providers should use the following rounding guidelines for procedure code T1013.

Time (Minutes)	Number of Interpretation Units Billed
8–22 minutes	1.0 unit
23–37 minutes	2.0 units
38–52 minutes	3.0 units
53–67 minutes	4.0 units
68–82 minutes	5.0 units
83–97 minutes	6.0 units

Claims for interpretive services must include HCPCS procedure code T1013 and the appropriate modifier(s):

- U1 (Spoken language)
- U3 (Sign Language)
- GT (Via interactive audio and video telecommunication systems)
- 93 (Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system)

Providers should refer to the interactive maximum allowable fee schedules for the reimbursement rate, covered provider types and specialties, modifiers, and the allowable POS (place of service) codes for procedure code T1013.

Delivery Method of Interpretive Services	Definition for Sign Language and Foreign Language Interpreters	Modifiers
In person (foreign language and sign language)	When the interpreter is physically present with the member and provider	U1 or U3
		U1 or U3

Telehealth* (foreign language and sign language)	When the member is located at an originating site and the interpreter is available remotely (via audio-visual or audio only) at a distant site		**and** GT or 93
	Phone (foreign language only)	When the interpreter is not physically present with the member and the provider and interprets via audio-only through the phone	U1 **and** 93
	Interactive video (foreign language and sign language)	When the interpreter is not physically present with the member and the provider and interprets on interactive video	U1 or U3 **and** GT

*Any telehealth service must be provided using HIPAA-compliant software or delivered via an app or service that includes all the necessary privacy and security safeguards to meet the requirements of HIPAA.

Dental Providers

Dental providers submitting claims for interpretive services are not required to include a modifier with procedure code T1013. Dental providers should retain documentation of the interpretive service in the member's records.

Allowable Places of Service

Claims for interpretive services must include a valid POS (place of service) code where the interpretive services are being provided.

Federally Qualified Health Centers

Non-tribal FQHCs (federally qualified health centers), also known as CHCs (community health centers), (POS code 50), will not receive direct reimbursement for interpretive services as these are indirect services assumed to be already included in the FQHC's bundled PPS (prospective payment system) rate. However, CHCs can still bill the T1013 code as an indirect procedure code when providing interpretive services. This billing process is similar to that of other indirect services provided by non-tribal FQHCs. This will enable DHS (Wisconsin Department of Health Services) to better track how FQHCs provide these services and process any future change in scope adjustment to increase their PPS rate that includes providing interpretive services.

Rural Health Clinics

RHCs (rural health clinics) (POS code 72) receives direct reimbursement for interpretive services. Procedure code T1013 should be billed when providing interpretive services.

Interpreter Qualifications

The two types of allowable interpreters include:

- Sign language interpreters—Professionals who facilitate the communication between a hearing individual and a person who is deaf or hard of hearing and uses sign language to communicate.
- Foreign language interpreters—Professionals who are fluent in both English and another language and listen to a

communication in one language and convert it to another language while retaining the same meaning.

Qualifications for Sign Language Interpreters

For Medicaid-enrolled providers to receive reimbursement, sign language interpreters must be licensed in Wisconsin under Wis. Stat. § 440.032 and must follow the specific requirements regarding education, training, and locations where they are able to interpret. The billing provider is responsible for determining the sign language interpreter's licensure and must retain all documentation supporting it.

Qualifications for Foreign Language Interpreters

There is not a licensing process in Wisconsin for foreign language interpreters. However, Wisconsin Medicaid strongly recommends that providers work through professional agencies that can verify the qualifications and skills of their foreign language interpreters.

A competent foreign language interpreter should:

- Be at least 18 years of age.
- Be able to interpret effectively, accurately, and impartially, both receptively and expressively, using necessary specialized vocabulary.
- Demonstrate proficiency in English and another language and have knowledge of the relevant specialized terms and concepts in both languages.
- Be guided by the standards developed by the National Council on Interpreting Health Care.
- Demonstrate cultural responsiveness regarding the LEP language group being served including values, beliefs, practices, languages, and terminology.

Topic #17937

Low-Dose Computed Tomography Scans

ForwardHealth covers low-dose CT (computed tomography) scans (identified by CPT (Current Procedural Terminology) procedure code 71271) for lung cancer screening without PA (prior authorization) as a preventive service for Wisconsin Medicaid and BadgerCare Plus-enrolled members who are at high risk for lung 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.

Providers are required to follow screening guidance from the USPSTF (United States Preventive Services Task Force) when ordering and performing lose-dose CT lung scans, including the USPSTF Final Recommendation Statement for Lung Cancer: Screening. Note: This screening guidance is subject to change.

USPSTF guidance currently includes, but is not limited to, the following:

- Members aged 50-80
- Members with a 20 pack-a-year smoking history, as indicated by the appropriate ICD (International Classification of Diseases, 10th Revision, Clinical Modification) diagnosis code
- Members who are either current smokers or have quit smoking within the past 15 years, as indicated by the appropriate ICD diagnosis code
- Members who have no signs or symptoms suggestive of underlying cancer

Topic #18177

Sleep Medicine Testing

Sleep medicine testing involves six or more hours of continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep with physician review, interpretation, and reporting. Polysomnography is distinguished from facility-based sleep studies and home-based sleep studies by the inclusion of sleep staging. Type IV sleep testing devices are not covered by ForwardHealth.

Coverage Requirements

Facility-Based Sleep Studies and Polysomnography

ForwardHealth covers facility-based sleep studies and polysomnography when ordered by the member's physician and performed in a sleep laboratory, an outpatient hospital, or an independent diagnostic testing facility for sleep disorders. Physicians interpretreting facility-based sleep studies and polysomnograms are required to have board certification in sleep medicine in order for the services to be reimbursed.

A list of allowable facility-based sleep study and polysomnography CPT (Current Procedural Terminology) procedure codes is available. Facility-based sleep study and polysomnography procedures do not require PA (prior authorization).

Home-Based Sleep Studies

ForwardHealth covers unattended home-based sleep studies when ordered by the member's physician. Physicians interpreting home-based sleep studies are required to have board certification in sleep medicine in order for the services to be reimbursed.

A list of allowable home-based sleep study HCPCS (Healthcare Common Procedure Coding System) procedure codes is available. Home-based sleep studies do not require PA.

Coverage Limitations for Sleep Medicine Testing

ForwardHealth does not cover the following:

- Unattended sleep studies for the diagnosis of obstructive sleep apnea in members with significant comorbid medical conditions that may affect the accuracy of the unattended sleep study, including, but not limited to, other sleep disorders
- Attendance of a nurse, home health aid, or personal care worker during a home-based sleep study
- Any parts of a home-based sleep study peformed by a DME (durable medical equipment) provider including, but not limited to, the delivery and/or pick up of the device
- Home-based sleep studies for children (ages 18 and younger)
- Abbreviated daytime sleep study (PAP-NAP) or daytime nap polysomnography

Topic #11097

Opioid Monthly Prescription Fill Limit

Opioid drugs are limited to five prescription fills per calendar month for BadgerCare Plus, Medicaid, and SeniorCare members.

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

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

- Buprenorphine products used for opioid use disorder tablet
- Liquid antitussive products containing opioids
- Methadone products used for opioid use disorder

Prescriber Responsibilities

If a member requires more than five opioid prescription fills in a month and the prescriber determines that a policy override is medically necessary, the prescriber may request a policy override through the DAPO (Drug Authorization and Policy Override) Center. An override is required for each opioid monthly prescription fill limit that exceeds the five-prescription fill limit per calendar month.

When calling the DAPO Center to request a policy override for the opioid monthly prescription fill limit, the following must be reviewed by the prescriber and the DAPO Center:

- The prescriber's name and NPI (National Provider Identifier)
- The member's name and ID
- The pharmacy's name and phone number where the member attempted to have the prescription filled
- The member's recent medication history
- The member's current opioid prescription information and if a policy override is medically necessary

The prescriber should notify the member and the pharmacy if an override of the opioid monthly prescription fill was authorized. If the prescriber determines that it is not medically necessary to authorize an override of the opioid monthly prescription fill limit for the member, the prescriber should contact the member and the pharmacy to cancel the current prescription fill and discuss follow-up care and when the next opioid prescription fill for the member will be approved.

Pharmacy Responsibilities

The prescriber may contact the pharmacy regarding an override of the opioid monthly prescription fill limit for the following reasons:

- The prescriber notifies the pharmacy that an override has been authorized.
- The prescriber notifies the pharmacy that an override was not authorized.

When pharmacies have been notified by the prescriber that an override has been authorized, the pharmacy should dispense the medication and submit the claim to ForwardHealth.

Note: If the prescriber does not call the pharmacy, the pharmacy provider should call the prescriber to confirm the status of the override and filling the opioid prescription for the member. If the pharmacy provider contacts the DAPO Center to authorize an override, the DAPO Center will inform the pharmacy provider that the prescriber is responsible for authorizing the override.

Pharmacies are responsible for submitting claims for opioids within three days of the override being authorized by the prescriber. If the pharmacy provider does not submit the claim within the three-day time period, the claim will be denied. If the claim is denied, the pharmacy cannot recoup the reimbursement from the member.

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

Opioid Prescription Limit Override Exceptions for Schedule III and IV Drugs and Schedule II Drugs

Schedule III and IV 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 or IV drug if all of the following conditions are met:

- The pharmacy attempted to contact the prescriber (or the prescriber's designee) but the prescriber is unavailable (for example, the clinic is closed).
- The pharmacy staff must document on the prescription order that the prescriber is not available.
- The pharmacist determined that dispensing a 96-hour supply is medically necessary.
- An 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 an exception if all of the following conditions are met:

- The pharmacy attempted to contact the prescriber (or the prescriber's designee), but the prescriber is unavailable (for example, the clinic is closed).
- The pharmacy staff must document on the prescription order that the prescriber is not available.
- The pharmacist determined that dispensing a 96-hour supply is medically necessary.
- An exception was not previously granted within the current calendar month; however, if the pharmacy was not aware of a previous exception within the current calendar month and dispensed the medication in good faith while the DAPO Center was closed, an override may be approved.

Note: The pharmacist may dispense a 96-hour supply exception for a Schedule III or IV drug.

Once the DAPO Center is open, the pharmacy must call to obtain the exception.

The exception may be retroactive up to five days (that is, backdated).

Schedule II Drugs

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

- The pharmacy attempted to contact the prescriber (or the prescriber's designee), but the prescriber is unavailable (for example, the clinic is closed).
- The pharmacy staff must document on the prescription order that the prescriber is not available.
- The pharmacist determined that it is medically necessary to dispense the drug.
- An exception for Schedule II drugs was not previously granted within the current calendar month.

Note: The pharmacist may dispense a supply exception for a Schedule II drug for 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 all of the following conditions are met:

- The pharmacy attempted to contact the prescriber (or the prescriber's designee), but the prescriber is unavailable (for example, the clinic is closed).
- The pharmacy staff documented on the prescription order that the prescriber is not available.
- The pharmacist determined that it is medically necessary to dispense the drug.
- An exception was not granted in the current calendar month; however, if the pharmacy was not aware of a previous exception within the current calendar month and dispensed the medication in good faith while the DAPO Center was closed, an override may be approved.

Note: The pharmacist may dispense a supply exception for a Schedule II drug for the full quantity indicated on the prescription

order.

Topic #23237

Over-the-Counter Contraception Standing Orders

The DMS (Division of Medicaid Services) chief medical officer issued the following standing orders for OTC (over-the-counter) contraception products:

- Standing Order for OTC Emergency Contraception for Members of Wisconsin's Medicaid Programs
- Standing Order for OTC Norgestrel (Opill) Pills for Members of Wisconsin's Medicaid Programs

The standing orders for OTC emergency contraception (levonorgestrel) and Opill (norgestrel) issued by the DMS chief medical officer enables enrolled BadgerCare Plus and Medicaid members to more easily obtain OTC oral contraception.

Over-the-Counter Emergency Contraception—Levonorgestrel

Levonorgestrel is a progestin-only emergency contraceptive indicated for the prevention of pregnancy following unprotected intercourse or a known or suspected contraceptive failure. Several manufacturers produce levonorgestrel emergency contraception products that are available for purchase by consumers without a prescription.

Over-the-Counter Oral Contraception—Opill (Norgestrel)

FDA (Food and Drug Administration)-approved Opill (norgestrel) is available without a prescription. Opill (norgestrel) is a progestin-only oral contraceptive for voluntary use by persons of reproductive potential to prevent pregnancy.

Information for Medicaid Pharmacy Providers

ForwardHealth covers oral contraceptives for members who are 10 through 65 years of age.

As a reminder, state Medicaid programs may only cover drugs produced by manufacturers who have signed a federal rebate agreement for the MDRP (Medicaid Drug Rebate Program). Non-participating manufacturers products cannot be covered. Pharmacies can refer to the Drug Search Tool to confirm that a specific OTC contraceptive product is covered by ForwardHealth.

If a member has an existing prescription from their provider, that prescription should be used. The standing orders do not supplant individual prescriptions.

Prior to dispensing an OTC emergency contraception or Opill (norgestrel) under their standing order, the provider should ensure all requirements of the standing order have been met and direct the member to review the manufacturer's instructions for use.

Note: Numerous OTC and legend contraception products not included in the standing orders are also available for coverage by ForwardHealth for BadgerCare Plus and Medicaid members when prescribed by a Medicaid-enrolled provider.

Levonorgestrel

Pharmacy providers may apply the emergency contraception standing order to fill a prescription for OTC emergency contraception (levonorgestrel). This standing order fulfills the requirement of a prescription for BadgerCare Plus and Medicaid members to obtain covered FDA-authorized OTC oral emergency contraception. It further authorizes providers to dispense such OTC products to BadgerCare Plus and Medicaid members to the extent a prescription is required, including for insurance coverage, under the pharmacy benefit.

Pharmacies may dispense up to four tablets per prescription dispensed under the emergency contraception standing order. OTC levonorgestrel products have a quantity limit of eight tablets per member per month applied. Pharmacies may request an override of the monthly quantity limit by contacting the DAPO (Drug Authorization and Policy Override) Center.

Opill (Norgestrel)

Pharmacy providers may apply the standing order issued by the DMS chief medical officer to fill a prescription for Opill (norgestrel). This standing order fulfills the requirement of a prescription for BadgerCare Plus and Medicaid members to obtain covered FDA-authorized OTC oral contraception. It further authorizes providers to dispense such OTC products to BadgerCare Plus and Medicaid members to the extent a prescription is required, including for insurance coverage, under the pharmacy benefit.

Pharmacies may dispense up to 84 tablets for a three-month supply per prescription with PRN (pro re nata) or "as needed" refills, which will allow for up to a one-year supply to be authorized per use of the OTC oral contraception standing order.

Requirements for a Valid Prescription

Any prescription for members, including those based on standing orders, must be documented according to Wis. Admin Code § DHS 107.02(2m)(b). For documentation purposes, "the prescriber's MA provider number" in Wis. Admin. Code § DHS 107.02 (2m)(b) refers to that of the provider who authored the standing order. Providers must follow licensure scope of practice requirements when delegating dispensing or treatment authority per standing order.

Topic #3545

Vaccines for Children Program

The federal VFC (Vaccines for Children) Program was created to provide vaccines to eligible children through enrolled public and private providers. The VFC Program is part of a national approach to improving immunization services and levels.

Any child 18 years of age or younger who meets at least one of the following criteria is eligible for the VFC Program:

- Eligible for BadgerCare Plus or Medicaid.
- American Indian or Alaska Native, as defined by the Indian Health Care Improvement Act.
- Uninsured.
- Underinsured. (These children have health insurance but the benefit plan does not cover immunizations. Children in this category may only receive immunizations from a FQHC (federally qualified health center) or an RHC (rural health clinic); they cannot receive immunizations from a private health care provider using a VFC-supplied vaccine.)

When a vaccine becomes available through the VFC Program, the VFC Program notifies providers with clinical information about new vaccines, including the date they may begin ordering the vaccine. On the first of the month following that date, ForwardHealth will begin reimbursing only the administration fee for that vaccine.

Benefits of the Vaccines for Children Program

The VFC Program provides the following benefits:

- Vaccines are provided at no charge to public and private providers to immunize all eligible children.
- Eliminates or reduces vaccine costs as a barrier to the vaccination of eligible children.
- Vaccines recommended by the ACIP (Advisory Committee on Immunization Practices) are automatically covered after approval by the CDC (Centers for Disease Control and Prevention).

Reimbursement for Vaccines Provided to Children

If a vaccine is available through the VFC Program, providers are required to use vaccines from the VFC supply for members 18 years of age or younger. ForwardHealth reimburses only the administration fee for vaccines supplied by the VFC Program.

For vaccines that are not supplied by the VFC Program, providers may use a vaccine from a private stock. In these cases, ForwardHealth reimburses for the vaccine and the administration fee.

Beyfortus (nirsevimab), a monoclonal antibody, is used for the prevention of lower respiratory tract disease caused by RSV (respiratory syncytial virus) in infants or children. Although not a vaccine, the CDC's ACIP voted to include Beyfortus in the VFC Program. Providers are required to obtain Beyfortus for children from the VFC supply. ForwardHealth only reimburses an administration code for Beyfortus supplied through the VFC Program.

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 CMR/A (Comprehensive Medication Review and Assessment) services, which 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 their 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

For the purposes of this Online Handbook topic, FQHC (federally qualified health center) refers to Tribal and Out-of-State FQHCs. This document does not apply to Community Health Centers subject to PPS (Prospective Payment System) reimbursement.

Services under the MTM benefit are not eligible for an allowable encounter; therefore, FQHCs 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 (Medication Therapy Management) documentation electronically using one of the following options:

- ForwardHealth-approved MTM 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.

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) 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.

Telehealth

Topic #22737

Behavioral Health Telehealth Services

Behavioral health services should be indicated by the following modifiers.

Modifier	Description
FQ*	A telehealth service was furnished using audio-only communication technology
FR*	A supervising practitioner was present through a real-time two-way, audio/video communication technology
GQ	Via asynchronous telecommunications system
GT	Via interactive audio and video telecommunication systems

*Use for behavioral health services **only**.

Topic #22738

Interprofessional Consultations (E-Consults)

An interprofessional consultation or e-consult is an assessment and management service in which a member's treating provider requests the opinion and/or treatment advice of a provider with specific expertise (the consultant) to assist the treating provider in the diagnosis and/or management of the member's condition without requiring the member to have face-to-face contact with the consultant. Both the treating and consulting providers may be reimbursed for the e-consult as described below.

Policy Requirements and Limitations

Consulting Providers

Consulting providers must be physicians enrolled in Wisconsin Medicaid as an eligible rendering provider. Consulting providers may bill CPT (Current Procedural Terminology) procedure codes 99446–99449 and 99451 under the following limitations:

- Services are not covered if the consultation leads to a transfer of care or other face-to-face service within the next 14 days or next available date of the consultant. Additionally, if the sole purpose of the consultation is to arrange a transfer of care or other face-to-face service, these procedure codes should not be submitted.
- Consulting services are covered once in a seven-day period.

Treating Providers

Treating providers may be a physician, nurse practitioner, physician assistant, or podiatrist enrolled in Wisconsin Medicaid as an eligible rendering provider. Treating providers may bill CPT procedure code 99452 as a covered service once in a 14-day period.

Both the consulting and treating providers must be enrolled in Wisconsin Medicaid to receive reimbursement for the e-consult and the consultation must be medically necessary.

Providers are expected to follow CPT guidelines including that the CPT procedure codes should not be submitted if the consulting provider saw the member in a face-to-face encounter within the previous 14 days.

Documentation Requirements

The following documentation requirements apply for e-consults:

- The consulting provider's opinion must be documented in the member's medical record.
- The written or verbal request for a consultation by the treating provider must be documented in the member's medical record including the reason for the request.
- Verbal consent for each consultation must be documented in the member's medical record. The member's consent must include assurance that the member is aware of any applicable cost-sharing.

Topic #22739

Originating and Distant Sites

The originating site is where the member is located during a telehealth visit. Only the provider at the originating site can bill for an originating site fee for hosting the member. The originating site should not use telehealth modifiers on the claims since all services are provided in-person. The distant site is where the provider is located during the telehealth visit. The provider who is providing health care services to the member via telehealth cannot bill the originating site fee because they are not hosting the member.

The following locations are eligible for the originating site fee under permanent telehealth policy:

- Office or clinic:
  - Medical
  - Dental
  - Therapies (physical therapy, occupational therapy, speech and language pathology)
  - Behavioral and mental health agencies
- Hospital
- Skilled nursing facility
- Community mental health center
- Intermediate care facility for individuals with intellectual disabilities
- Pharmacy
- Day treatment facility
- Residential substance use disorder treatment facility

Claims Submission and Reimbursement for Distant Site Providers

Claims for services provided via telehealth by distant site providers must be billed with the same procedure code as would be used for a face-to-face encounter along with modifiers GQ, GT, FQ, or 93.

Note: Only the service rendered from the distant site must be billed with modifier GQ. The originating site for asynchronous services is not eligible to receive an originating site fee.

Claims must also include either POS (place of service) code 02 or 10. ForwardHealth reimburses the service rendered by distant site providers at the same rate as when the service is provided face-to-face.

Ancillary Providers

Claims for services provided via telehealth by distant site 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 (Current Procedural Terminology) code for the service performed. These services must be provided under the direct on-site supervision of a physician who is located at the same physical site as the ancillary provider and must be documented in the same manner as services that are provided face to face.

Refer to the Supervision topic for additional information.

Pediatric and Health Professional Shortage Area-Eligible Services

Claims for services provided via telehealth by distant site providers may additionally qualify for pediatric (services for members 18 years of age and under) or HPSA (Health Professional Shortage Area)-enhanced reimbursement. Pediatric and HPSA-eligible providers are required to indicate POS code 02 or 10, along with modifier GQ, GT, FQ, or 93 and the applicable pediatric or HPSA modifier, when submitting claims that qualify for enhanced reimbursement.

Claims Submission and Reimbursement for Originating Site Fee

In addition to reimbursement to the distant site provider, ForwardHealth reimburses an originating site fee for the staff and equipment at the originating site requisite to provide a service via telehealth. Eligible providers who serve as the originating site should bill the fee with HCPCS procedure code Q3014 (Telehealth originating site fee). Modifier GQ, GT, FQ, or 93 should not be included with procedure code Q3014.

Outpatient hospitals, including emergency departments, must bill HCPCS procedure code Q3014 on an institutional claim form as a separate line item with revenue code 0780. ForwardHealth will reimburse hospitals for the fee based on the standard hospital reimbursement methodology. ForwardHealth will reimburse these providers for the fee based on the provider's standard reimbursement methodology.

All other providers should bill HCPCS procedure code Q3014 with a POS code that represents where the member is located during the service. The POS must be a ForwardHealth-allowable originating site for HCPCS procedure code Q3014 in order to be reimbursed for the originating site fee. Billing-only provider types must include an allowable rendering provider on the claim form. The originating site fee is reimbursed based on a maximum allowable fee.

Although FQHCs are not directly reimbursed an originating site fee, HCPCS procedure code Q3014 should be billed for tracking purposes and for consideration in any potential future changes in scope.

To receive reimbursement, the originating site must:

- Utilize an interactive audiovisual telecommunications system that permits real-time communication between the provider at the distant site and the member at the originating site.
- Be in a physical location that ensures privacy.
- Provide access to broadband internet with sufficient bandwidth to transmit audio and video data.
- Provide access to support staff to assist with technical components of the telehealth visit.
- Be compliant with Health Insurance Portability and Accountability Act of 1996 standards.

Federally Qualified Health Centers and Rural Health Clinics

For the purpose of this Online Handbook topic, FQHC (Federally Qualified Health Center) refers to Tribal and Out-of-State FQHCs. This topic does not apply to Community Health Centers subject to PPS (prospective payment system) reimbursement.

FQHCs and RHCs (rural health clinics) may serve as originating site and distant site providers for telehealth services.

Distant Site

FQHCs and RHCs may report services provided via telehealth on the cost settlement report when the FQHC or RHC served as the distant site and the member is an established patient of the FQHC or RHC at the time of the telehealth service. For currently covered services, services that are considered direct when provided in-person will be considered direct when provided via telehealth for FQHCs.

Services billed with modifier GQ, GT, FQ, or 93 will be considered under the PPS (prospective payment system) reimbursement method for non-tribal FQHCs. Billing HCPCS procedure code T1015 (Clinic visit/encounter, all-inclusive) with a telehealth procedure code will result in a PPS rate for fee-for-service encounters. Fee-for-service claims must include HCPCS procedure code T1015 when services are provided via telehealth in order for proper reimbursement.

Originating Site

The originating site fee is not a FQHC or RHC reportable encounter on the cost report. Any reimbursement for the originating site fee must be reported as a deductive value on the cost report.

Topic #22740

Remote Patient Monitoring

Remote Physiologic Monitoring

Remote physiologic monitoring is the collection and interpretation of a member's physiologic data, such as blood pressure or weight checks, that are digitally transmitted to a physician, nurse practitioner, or physician assistant for use in the treatment and management of medical conditions that require frequent monitoring. Such conditions include congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, and mental or behavioral problems. It is also used for members receiving technology-dependent care, such as continuous oxygen, ventilator care, total parenteral nutrition, or enteral feeding.

Eligible Devices

The device used to capture a member's physiologic data must meet the Food and Drug Administration definition of a medical device. To submit claims for CPT (Current Procedural Terminology) procedure codes 99453–99458, the members' physiologic data must be wirelessly synced so it can be evaluated by the physician, nurse practitioner, or physician assistant. Transmission can be synchronous or asynchronous (data does not have to be transmitted in real time as long as it is automatically updated on an ongoing basis for the provider to review).

Policy Requirements

The following policy requirements apply for remote physiologic monitoring services:

- Only physicians, nurse practitioners, and physician assistants enrolled in ForwardHealth are eligible to render and submit claims for remote physiologic services.
- The member's consent for remote physiologic monitoring services must be documented in the member's medical record.
- The provider must document how remote physiologic monitoring is tied to the member-specific needs and will assist the member to achieve the goals of treatment.
- Services are not separately reimbursable if the services are bundled or covered by other procedure codes (for example, continuous glucose monitoring is covered under CPT procedure code 95250 and should not be submitted under CPT procedure codes 99453–99454).
- CPT procedure codes 99453 and 99454 can be used for blood pressure remote physiologic monitoring if the device used to measure blood pressure meets remote physiologic monitoring requirements. If the member self-reports blood pressure readings, the provider must instead submit self-measured blood pressure monitoring CPT procedure codes 99473–99474.

- CPT procedure code 99457 should be used when the physician, nurse practitioner, or physician assistant uses medical decision making based on interpreted data received from a remote physiologic monitoring device to assess the member's clinical stability, communicate the results to the member, and oversee the management and/or coordination of services as needed.

Providers are expected to follow CPT guidelines.

Claim Submission

Special modifiers are not required or requested for remote physiologic monitoring services. Providers should follow appropriate claim submission requirements as outlined in the Online Handbook.

Topic #22757

Supervision

Supervision requirements and respective telehealth allowances vary depending on service and provider type. Some supervision requirements necessitate the physical presence of the supervising provider to meet the requirements of appropriate delivery of supervision. Such requirements cannot be met through the provision of telehealth, including audio-visual delivery.

Providers who deliver services with supervision requirements are reminded to review ForwardHealth policy, including permanent telehealth policy, and the requirements of their licensing and/or certifying authorities to determine if the supervisory components of the service can be met via telehealth.

Supervision of Paraprofessional Providers

Paraprofessional providers are subject to supervision requirements. Paraprofessional providers are providers who do not hold a license to practice independently but are providing services under the direction of a licensed provider. Providers who supervise paraprofessionals are responsible for confirming if the required components of supervision can be met through telehealth delivery.

Personal Care/Home Health Provider Supervision

Supervision of PCWs (personal care workers) and home health aides must be performed on site and in person by the RN (registered nurse). State rules and regulations necessitate supervising providers to physically visit a member's home and directly observe the paraprofessional providing services.

Direct Supervision for Ancillary Care Providers

Ancillary providers have specific requirements when providing care via telehealth. These providers are health care professionals that are not enrolled in Wisconsin Medicaid, such as staff nurses, dietician counselors, nutritionists, health educators, genetic counselors, and some nurse practitioners who practice under the direct supervision of a physician and bill under the supervising physician's NPI (National Provider Identifier). (Nurse practitioners, nurse midwives, and anesthetists who are Medicaid-enrolled should refer to their service-specific area of the Online Handbook for billing information).

For telehealth services, the supervising physician is not required to be onsite, but they must be able to interact with the member using real-time audio or audiovisual communication, if needed. For supervision of ancillary providers, remote supervision is allowed in circumstances where the physician feels the member is not at risk of an adverse event that would require hands-on intervention from the physician.

Supervision for Behavioral Health Services

The FR modifier should be used for behavioral health services where the supervising provider is present through audio-visual means and the patient and supervised provider are in-person.

Documenting Supervision Method

Providers should include how the service and the required supervision occurred in the member record and, if applicable, indicate the appropriate modifier on the claim form. For example, for a behavioral health service where the supervising provider is present through audio-visual means and the patient and supervised provider are in-person, modifier FR should be indicated on the claim.

Topic #22837

Telehealth Definitions

General Telehealth Definitions

"Telehealth" means the use of telecommunications technology by a Medicaid-enrolled provider to deliver functionally equivalent health care services including: assessment, diagnosis, consultation, treatment, and transfer of medically relevant data. Telehealth may include real-time interactive audio-only communication. Telehealth does not include communication between a provider and a member that consists solely of an email, text, or fax transmission.

"Synchronous" telehealth services are two-way, real-time, interactive communications. They may include audio-only (telephone) or audio-visual communications.

"Asynchronous" telehealth services are defined as telehealth that is used to transmit medical data about a patient to a provider when the transmission is not a two-way, real-time, interactive communication.

"Functionally equivalent" means that when a service is provided via telehealth, the transmission of information must be of sufficient quality as to be the same level of service as an in-person visit. Transmission of voices, images, data, or video must be clear and understandable.

Telehealth Service Definitions

The following are definitions to clarify the meaning of existing terms that describe different modes of telehealth service delivery in telehealth policy.

"In-person" refers to when the provider rendering a service and the member receiving that service are located together physically in the same space. In-person services are not considered to be delivered through telehealth, including audio-visual telehealth, unless there are applicable supervision components and requirements that are rendered through telehealth outside of the direct patient contact by the provider.

"Face-to-face" refers to requirements that can be met either in-person or through real-time, interactive audio-visual telehealth. An interactive telehealth service with face-to-face components must be functionally equivalent to an in-person service. It is delivered from outside the physical presence of a Medicaid member by using audio-visual technology, and there is no reduction in quality, safety, or effectiveness. ForwardHealth does not consider a "face-to-face" requirement to be met by audio-only or asynchronous delivery of services.

Under telehealth policy, "direct" refers to an in-person contact between a member and a provider. Direct services often require a provider to physically touch or examine the recipient and delegation is not appropriate.

Topic #510

Telehealth Policy

Both synchronous (two-way, real-time, interactive communications) and asynchronous (information stored and forwarded to a provider for later review) services identified under permanent policy may be reimbursed when provided via telehealth (also known as "telemedicine"). ForwardHealth will require providers to follow permanent billing guidelines for both synchronous and asynchronous telehealth services.

Telehealth enables a provider who is located at a distant site to render the service remotely to a member located at an originating site using a combination of interactive video, audio, and externally acquired images through a networking environment.

"Telehealth" means the use of telecommunications technology by a Medicaid-enrolled provider to deliver functionally equivalent health care services including assessment, diagnosis, consultation, treatment, and transfer of medically relevant data. Telehealth may include real-time interactive audio-only communication. Telehealth does not include communication between a provider and a member that consists solely of an email, text, or fax transmission.

"Functionally equivalent" means that when a service is provided via telehealth, the transmission of information must be of sufficient quality as to be the same level of service as an in-person visit. Transmission of voices, images, data, or video must be clear and understandable.

Note: Temporary telehealth policy that will become permanent policy shortly after the Federal Health Emergency expires is included in this topic.

Telehealth Policy Requirements

The following requirements apply to the use of telehealth:

- Both the member and the provider of the health care service must agree to the service being performed via telehealth. If either the member or provider decline the use of telehealth for any reason, the service should be performed in-person.
- The member retains the option to refuse the delivery of health care services via telehealth at any time without affecting their right to future care or treatment and without risking the loss or withdrawal of any program benefits to which they would otherwise be entitled.
- Medicaid-enrolled providers must be able and willing to refer members to another provider if necessary, such as when telehealth services are not appropriate or cannot be functionally equivalent, or the member declines a telehealth visit.
- Title VI of the Civil Rights Act of 1964 requires recipients of federal financial assistance to take reasonable steps to make their programs, services, and activities accessible by eligible persons with limited English proficiency.
- The Americans with Disabilities Act requires that health care entities provide full and equal access for people with disabilities.

Allowable Services

Providers should refer to the Max Fee Schedules page for a complete list of services allowed under permanent telehealth policy. Effective for dates of service on and after April 1, 2022, procedure codes for services allowed under permanent telehealth policy have POS codes 02 and 10 listed as an allowable POS in the fee schedule. Complete descriptions of these POS codes are as follows:

- POS code 02: Telehealth Provided Other Than in Patient's Home–The location where health services and health related services are provided or received through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.
- POS code 10: Telehealth Provided in Patient's Home–The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health

related services through telecommunication technology.

Claims for services delivered via telehealth must include all modifiers required by the existing benefit coverage policy in order to reimburse the claim correctly. Telehealth delivery of the service is shown on the claim by indicating POS code 02 or 10 and including either the GQ, GT, FQ, or 93 modifier in addition to any other required benefit-specific modifiers.

County-administered programs, school-based services, and any other programs that utilize cost reporting must include required modifiers, such as renderer credentials and group versus individual services, as well as correct details for cost reporting to ensure correct reimbursement.

Note: The GT, FQ or 93 modifiers may not be listed on the fee schedule, but it is still required on all claim submissions that use POS code 02 or 10 to indicate the telehealth service was performed synchronously. The GQ modifier is required to indicate the telehealth service was performed asynchronously.

Services Not Appropriate Via Telehealth

Certain types of benefits or services that are not appropriately delivered via telehealth include:

- Services that are not covered when provided in-person.
- Services that do not meet applicable laws, regulations, licensure requirements, or procedure code definitions if delivered via telehealth.
- Services where a provider is required to physically touch or examine the recipient and delegation is not appropriate.
- Services the provider declines to deliver via telehealth.
- Services the recipient declines to receive via telehealth.
- Transportation services.
- Services provided by personal care workers, home health aides, private duty nurses, or school-based service care attendants.

Reimbursement for Covered Services

The health care provider at the distant site must determine the following:

- The service delivered via telehealth meets the procedural definition and components of the CPT or HCPCS procedure code, as defined by the American Medical Association, or the CDT (Current Dental Terminology) procedure code, as defined by the American Dental Association.
- The service is functionally equivalent to an in-person service for the individual member and circumstances.

Reimbursement is not available for services that cannot be provided via telehealth due to technical or equipment limitations.

Documentation Requirements

Documentation requirements for a telehealth service are the same as for an in-person visit and must accurately reflect the service rendered. Documentation must identify the delivery mode of the service when provided via telehealth and document the following:

- Whether the service was provided via audio-visual telehealth, audio-only telehealth, or via telehealth externally acquired images
- Whether the service was provided synchronously or asynchronously

Additional information for which documentation is recommended, but not required, includes:

- Provider location (for example, clinic [city/name], home, other)
- Member location (for example, clinic [city/name], home)

- All clinical participants, as well as their roles and actions during the encounter (This could apply if, for example, a member presents at a clinic and receives telehealth services from a provider at a different location.)

As a reminder, documentation for originating sites must support the member's presence in order to submit a claim for the originating site fee. In addition, if the originating site provides and bills for services in addition to the originating site fee, documentation in the member's medical record should distinguish between the unique services provided.

Audio-Only Guidelines

When possible, telehealth services should include both an audio and visual component. In circumstances where audio-visual telehealth is not possible due to member preference or technology limitations, telehealth may include real-time interactive audio-only communication if the provider feels the service is functionally equivalent to the in-person service and there are no face-to-face or in-person restrictions listed in the procedural definition of the service.

Documentation should include that the service was provided via interactive synchronous audio-only telehealth.

Modifier 93 should be used for any service performed via audio-only telehealth. The GT modifier should only be used to indicate services that were performed using audio-visual technology.

Member Consent Guidelines for Telehealth

On at least an annual basis, providers should supply and document that:

- The member expressed an understanding of their right to decline services provided via telehealth.
- Providers should develop and implement their own methods of informed consent to verify that a member agrees to receive services via telehealth. These methods must comply with all federal and state regulations and guidelines.
- Providers have flexibility in determining the most appropriate method to capture member consent for telehealth services. Examples of allowable methods include educating the member and obtaining verbal consent prior to the start of treatment or telehealth consent and privacy considerations as part of the notice of privacy practices.

Privacy and Security

Providers are required to follow federal laws to ensure member privacy and security. This may include ensuring that:

- The location from which the service is delivered via telehealth protects privacy and confidentiality of member information and communications.
- The platforms used to connect to the member to the telehealth visit are secure.

Group Treatment

Additional privacy considerations apply to members participating in group treatment via telehealth. Group leaders should provide members with information on the risks, benefits, and limits to confidentiality related to group telehealth and document the member's consent prior to the first session. Group leaders should adhere to and uphold the highest privacy standards possible for the group.

Group members should be instructed to respect the privacy of others by not disclosing group members' images, names, screenshots, identifying details, or circumstances. Group members should also be reminded to prevent non-group members from seeing or overhearing telehealth sessions.

Providers may not compel members to participate in telehealth-based group treatment and should make alternative services available for members who elect not to participate in telehealth-based group treatment.

Costs Member Cannot Be Billed For

The following cannot be billed to the member:

- Telehealth equipment like tablets or smart devices
- Charges for mailing or delivery of telehealth equipment
- Charges for shipping and handling of:
  - Diagnostic tools
  - Equipment to allow the provider to assess, diagnose, repair, or set up medical supplies online such as hearing aids, cochlear implants, power wheelchairs, or other equipment

Allowable Providers

There is no restriction on the location of a distant site provider. In addition, there are no limitations on what provider types may be reimbursed for telehealth services.

Requirements and Restrictions

Services provided via telehealth must be of sufficient audio and visual fidelity and clarity as to be functionally equivalent to a face-to-face visit where both the rendering provider and member are in the same physical location. Both the distant and originating sites must have the requisite equipment and staffing necessary to provide the telehealth service.

Coverage of a service provided via telehealth is subject to the same restrictions as when the service is provided face to face (for example, allowable providers, multiple service limitations, PA (prior authorization)).

Providers are reminded that HIPAA (Health Insurance Portability and Accountability Act of 1996) confidentiality requirements apply to telehealth services. When a covered entity or provider utilizes a telehealth service that involves PHI (protected health information), the entity or provider will need to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to PHI confidentiality, integrity, and availability. Each entity or provider must assess what are reasonable and appropriate security measures for their situation.

Note: Providers may not require the use of telehealth as a condition of treating a member. Providers must develop and implement their own methods of informed consent to verify that a member agrees to receive services via telehealth. These methods must comply with all federal and state regulations and guidelines.

Noncovered Services

Services that are not covered when delivered in person are not covered as telehealth services. In addition, services that are not functionally equivalent to the in-person service when provided via telehealth are not covered.

Additional Policy for Certain Types of Providers

Out-of-State Providers

ForwardHealth policy for services provided via telehealth by out-of-state providers is the same as ForwardHealth policy for services provided face to face by out-of-state providers.

Out-of-state providers who meet the definition of a border-status provider as described in Wis. Admin. Code § DHS 101.03(19) and who provide services to Wisconsin Medicaid members only via telehealth, may apply for enrollment as Wisconsin telehealth-only border-status providers if they are licensed in Wisconsin under applicable Wisconsin statute and administrative code.

Out-of-state providers who do not have border status enrollment with Wisconsin Medicaid are required to obtain PA before

providing services via telehealth to BadgerCare Plus or Medicaid members.

Note: Wisconsin Medicaid is prohibited from paying providers located outside of the United States and its territories, including the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

Topic #22741

Telestroke Services

Telestroke, also known as stroke telemedicine, is a delivery mechanism of telehealth services that aims to improve access to recommended stroke treatment.

ForwardHealth allows providers to be reimbursed for telestroke services. Telestroke services typically consist of the member and emergency providers at an originating site consulting with a specialist located at a distant site.

Claims Submission for Telestroke Services

Providers are required to use CPT (Current Procedural Terminology) consultation and E&M (evaluation and management) procedure codes when billing telestroke services. Telestroke services are subject to the same enrollment policy, coverage policy, and billing policy as telehealth services. All other services rendered by the provider at the originating site, and by any providers to which the member is transferred, should be billed in the same manner as visits or admissions that do not involve telehealth services.

Originating sites that have established contractual relationships for telestroke services may bill as they would for any other contracted professional services for both the professional service claim on behalf of the distant site provider and the originating site fee.

Topic #22742

Virtual Check-In, E-Visit, and Telephone Evaluation and Management Services

ForwardHealth includes virtual check-in and e-visit options for members to connect with their providers remotely.

A **virtual check-in** is a brief patient-initiated asynchronous or synchronous communication and technology-based service intended to be used to decide whether an office visit or other service is needed. The encounter may involve synchronous discussion over a phone or exchange of information through video or image. A provider may respond to the member's concern by phone, audio-visual communications, or a secure patient portal. Covered services include both the remote evaluation of a recorded video or image submitted by a member and the interpretation and follow-up by the provider.

An **e-visit** is a communication between a member and their provider through an online HIPAA (Health Insurance Portability and Accountability Act of 1996)-compliant patient portal. These patient-initiated asynchronous services involve a member having non-face-to-face communications cumulatively over a span of seven days with a provider with whom they have an established relationship. Providers who can bill E&M (evaluation and management) services may utilize online digital E&M codes while other providers may be eligible to bill online assessment and management codes.

Allowable procedure codes for virtual check-in and e-visit services:

Virtual Check-In Procedure Code	Description

Physician Services	
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (eg, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E&M service provided within the previous seven days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment
G2012	Brief communication technology-based service (eg, virtual check-in), by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E&M service provided within the previous seven days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion
G2252	Brief communication technology-based service (eg, virtual check-in), by a physician or other qualified health care professional who can report Evaluation and Management services, provided to an established patient, not originating from a related E&M service provided within the previous seven days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 11–20 minutes of medical discussion
Therapies (PT, OT, SLP) Services	
G2250	Remote assessment of recorded video and/or images submitted by an established patient (eg, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous seven days nor leading to a service or procedure within the next 24 hours or soonest available appointment
G2251	Brief communication technology-based service (eg, virtual check-in), by a qualified health care professional who cannot report Evaluation and Management services, provided to an established patient, not originating from a related service provided within the previous seven days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of clinical discussion

E-Visit Procedure Code	Description
Therapies (PT, OT, SLP) Services	
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 5–10 minutes
98971	Qualified nonphysician health care professional online digital assessment and management service, for an established patient, for up to seven days, cumulative time during the seven days; 11–20 minutes
98972	Qualified nonphysician health care professional online digital assessment and management service, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes
Physician Services	
99421	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; 5–10 minutes
99422	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; 11–20 minutes
99423	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative

	time during the seven days; 21 or more minutes

These services do not require prior authorization and are patient-initiated by established patients of the provider's practice.

Virtual check-in and e-visit telehealth services are not covered or billable if they:

- Take place during an in-person visit.
- Take place within seven days after an in-person visit furnished by the same provider.
- Trigger an in-person visit within 24 hours or the soonest available appointment.
- Do not have sufficient information from the remote evaluation of an image or video (store and forward) for the provider to complete the service.

Only the relevant in-person procedure code that was rendered would be reimbursed if any of the above conditions apply.

Telephone Evaluation and Management Services

ForwardHealth allows the following procedure codes to be reimbursable for telephone E&M services:

Telephone E&M Services Procedure Code	Description
Physician Services	
99441	Telephone evaluation and management service by a physician or other qualified health professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E&M service provided within the previous seven days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion
99442	Telephone evaluation and management service by a physician or other qualified health professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E&M service provided within the previous seven days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 11–20 minutes of medical discussion
99443	Telephone evaluation and management service by a physician or other qualified health professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E&M service provided within the previous seven days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 21–30 minutes of medical discussion

Prior Authorization

3

Archive Date:04/01/2024

Prior Authorization:Services Requiring Prior Authorization

Topic #19817

Personal Continuous Glucose Monitoring Devices and Accessories

PA (prior authorization) is required for coverage of personal continuous glucose monitoring devices and transmitters, but it is not required for sensors.

Prior Authorization Approval Criteria

PA requests for personal continuous glucose monitoring devices and transmitters may be approved for members who meet all of the following criteria:

- The member has Type 1 and/or Type 2 diabetes mellitus.
- The member is 21 years of age or older.
- The member is insulin-treated with multiple daily administrations of insulin or a continuous subcutaneous insulin infusion pump.
- The member has the motivation to use a personal continuous glucose monitoring device on a near-daily basis and has the ability and readiness, as assessed by their medical team, to make appropriate adjustments to their treatment regimen from the trending information obtained from the continuous glucose monitoring device.
- The member is receiving in-depth diabetes education and is in regular close contact with their diabetes management team.

For members who do not have Type 1 and/or Type 2 diabetes, coverage of personal continuous glucose monitoring devices will be considered on a case-by-case basis and reviewed for medical necessity.

ForwardHealth will consider coverage of a personal continuous glucose monitoring device on a case-by-case basis for members under 21 years old who meet the above criteria despite appropriate modifications in insulin regimen. Success of a personal continuous glucose monitoring device is highly dependent on compliance, especially for members under 21 years old. Documentation for members under 21 years old must include an assessment by an endocrinologist or diabetes educator of readiness of the member to use the device on a near-daily basis, as well as clear documentation that the member or the member's caregiver is compliant with self-monitoring as described above.

ForwardHealth does not cover personal continuous glucose monitoring devices for conditions that do not have sufficient evidence of the efficacy of continuous glucose monitoring (for example, gestational diabetes).

Prior Authorization Documentation

All of the following must be included as part of a PA request for personal continuous glucose monitoring devices and/or accessories:

- A completed PA/RF (Prior Authorization Request Form, F-11018 (05/2013))
- A completed PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (02/2024))
- Documentation of the member's diagnosis of Type 1 and/or Type 2 diabetes mellitus
- A written prescription from a licensed medical professional on the member's medical team
- The following information about the continuous glucose monitoring device:
    - Name of the manufacturer of the device

    - Make of the device
    - Statement regarding whether or not the device is FDA (Food and Drug Administration)-approved
- A description of the member's compliance with a physician-ordered diabetic treatment plan, including regular self-monitoring and insulin-treated with multiple daily administrations of insulin or a continuous subcutaneous insulin infusion pump
- Documentation of member and/or caregiver in-person training and available ongoing support in sensor placement, transmitter hookup, and monitor calibration, and an assessment from a licensed medical professional on the member's medical team of the member's ability to self-manage treatment according to information obtained from the monitor

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), MR (magnetic resonance), and MRE (magnetic resonance elastography) 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 (for example, ACR Select, Medicalis) as an alternative to current PA requirements for CT, MR, and MRE imaging services. Requesting providers with an approved tool will not be required to obtain PA through eviCore healthcare 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 eviCore healthcare) 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, MR, and MRE imaging services using the following process:

1. Complete a Prior Authorization Requirements Exemption Request for CT, MR, and MRE Imaging Services (Prior Authorization Requirements Exemption Request for Computed Tomography (CT), Magnetic Resonance (MR), and Magnetic Resonance Elastography (MRE) Imaging Services, F-00787 (02/2019)) and agree to its terms.
2. Submit the completed Prior Authorization Requirements Exemption Request for CT, MR, and MRE Imaging Services to the mailing or email 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, MR, and MRE 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 email 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, MR, and MRE 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, MR, and MRE Imaging Services form for more detailed information on quality improvement plans and maintaining exemption from PA requirements. Providers with questions regarding the requirements may email 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 email 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, MR, and MRE 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 email 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, MR, and MRE 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 eviCore healthcare 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, MR, or MRE 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), MRE (magnetic resonance elastography), 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). eviCore healthcare, 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, MR, and MRE 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, MR, and MRE imaging services.

Claims

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Archive Date:04/01/2024

Claims: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 website, 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 (for example, commercial health insurance, Medicare, Medicare Advantage Plans) sources must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth. When submitting paper claims, if the member has any other health insurance sources, providers are required to complete and submit an Explanation of Medical Benefits form, along with the completed paper claim.

Submit completed paper claims and the completed Explanation of Medical Benefits form, as applicable, 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 (not required)
This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (for example, commercial health insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate Explanation of Medical Benefits form for each other payer as an attachment(s) to their completed paper claim.

Item Number 9a — Other Insured's Policy or Group Number (not required)
This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (for example, commercial health insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate Explanation of Medical Benefits form for each other payer as an attachment(s) to their completed paper claim.

Item Number 9d — Insurance Plan Name or Program Name (not required)
This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (for example, commercial health insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate Explanation of Medical Benefits form for each other payer as an attachment(s) to their completed paper claim.

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 website under Code Sets.

Item Number 11 — Insured's Policy Group or FECA Number (not required)
This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (for example, commercial health insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate Explanation of Medical Benefits form for each other payer as an attachment(s) to their completed paper claim.

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 physician-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 (not required)
This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (for example, commercial health insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate Explanation of Medical Benefits form for each other payer as an attachment(s) to their completed paper claim.

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 eviCore healthcare 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 when completed during a covered observation stay.

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), MR (magnetic resonance), and MRE (magnetic resonance elastography) 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, MR, and MRE imaging services. Requesting providers with an approved tool will not be required to obtain PA through eviCore healthcare 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, MR, or MRE 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 #20082

Claims for Drugs Purchased Through the 340B Drug Pricing Program

Providers are required to submit accurate claim-level identifiers to identify claims for drugs purchased through the 340B Program (340B Drug Pricing Program). ForwardHealth uses submission clarification codes on compound and noncompound drug claims and a modifier on professional claims to identify claims for drugs purchased through the 340B Program. ForwardHealth monitors claims for the appropriate submission clarification code or modifier based on whether or not providers have designated themselves on the HRSA (Health Resources & Services Administration) 340B MEF (Medicaid Exclusion File).

ForwardHealth uses claim-level identifiers to identify claims for drugs purchased through the 340B Program in order to exclude these claims from the drug rebate invoicing process. It is the responsibility of the 340B covered entity to indicate the AAC (Actual Acquisition Cost) and to correctly report claims filled with 340B inventory for 340B-eligible members to ensure rebates are not collected for these drugs. If a rebate is received by ForwardHealth for a drug purchased through the 340B Program due to incorrect claim-level identifiers, the 340B covered entity will be responsible to reimburse the manufacturer the 340B discount.

A 340B contract pharmacy must carve-out ForwardHealth from its 340B operation and purchase all drugs billed to ForwardHealth outside of the 340B Program.

Pharmacy Compound and Noncompound Claim Submission Clarification Codes for Drugs Purchased Through the 340B Drug Pricing Program

The compound and noncompound drug claim formats require submission clarification codes in order to identify claims for drugs purchased through the 340B Program. ForwardHealth uses the submission clarification code value to ensure appropriate rebate processes and avoid duplicate discounts. Providers should only submit claims for drugs purchased through the 340B Program if the provider is present on the HRSA 340B MEF.

ForwardHealth relies solely on these claim level identifiers to identify claims for drugs purchased through the 340B Program. If a 340B claim level identifier is present, then the claim will be excluded from the drug rebate invoicing process.

The following submission clarification codes are applicable to compound and noncompound drug claims submitted by 340B providers:

- "20" (340B) — Providers who submit a compound or noncompound drug claim for a drug purchased through the 340B Program are required to enter submission clarification code "20" to indicate that the provider determined the drug being billed on the claim was purchased pursuant to rights available under Section 340B of the Public Health Act of 1992. ForwardHealth uses the submission clarification code value of "20" to apply 340B reimbursement and to ensure that only eligible claims are being used to obtain drug manufacturer rebates. The claim will be reimbursed at the lesser of the calculated 340B ceiling price or the provider-submitted 340B AAC plus a professional dispensing fee. If a calculated 340B ceiling price is not available for a drug, ForwardHealth will reimburse 340B ingredient cost at the lesser of WAC (Wholesale Acquisition Cost) minus 50 percent or the provider-submitted 340B AAC plus a professional dispensing fee.
- "99" (Other) — If a provider who is listed on the HRSA 340B MEF submits a compound or noncompound drug claim without submission clarification code "20," the claim will be denied with an EOB (Explanation of Benefits) code stating they are a 340B provider submitting a claim for a drug not purchased through the 340B Program. Once a provider has verified that the claim is not for a drug purchased through the 340B Program, they should resubmit the claim with submission clarification code "99" to verify that the claim was submitted as intended and is not a claim for a drug purchased through the 340B Program. A claim with a submission clarification code of "99" will be reimbursed at the lesser of the current ForwardHealth reimbursement rate or the billed amount plus a professional dispensing fee. 340B reimbursement will not be applied.
- "2" (Other Override) — If a submitting provider is not listed on the HRSA 340B MEF but submits a compound or noncompound drug claim for a drug purchased through the 340B Program (by indicating a submission clarification code of "20"), the claim will be denied with an EOB code stating they are not on the HRSA 340B MEF. If the provider believes they are or should be on the HRSA 340B MEF as a 340B-covered entity choosing to carve-in for Wisconsin Medicaid, the provider should resubmit the claim with submission clarification code "2" to indicate that the claim is for a drug purchased through the 340B Program. The provider should also contact HRSA to update the HRSA 340B MEF with the provider's information. Covered entities are responsible for the accuracy of the information in the HRSA 340B MEF. A claim with a submission clarification code of "2" will be reimbursed at the lesser of the calculated 340B ceiling price or the provider-submitted 340B AAC plus a professional dispensing fee. If a calculated 340B ceiling price is not available for a drug, ForwardHealth will reimburse 340B ingredient cost at the lesser of WAC minus 50 percent or the provider-submitted 340B AAC plus a professional dispensing fee.

Note: The compound drug claim format only accepts one submission clarification code value. If a compound drug includes an ingredient that was purchased through the 340B Program, the provider should use the appropriate submission clarification code to identify the claim is for a drug purchased through the 340B Program, and ForwardHealth will assume the submission clarification code "8" (Process Compound for Approved Ingredients) applies to all ingredients of the compound drug claim.

Basis of Cost Determination and Submission Clarification Code

The Basis of Cost Determination is a required field in which the provider is required to submit the appropriate code indicating the method by which "ingredient cost submitted" was calculated. Providers are responsible for submitting a valid Basis of Cost Determination value, per the ForwardHealth Payer Sheet: NCPDP Version D.0 (ForwardHealth Payer Sheet: National Council for Prescription Drug Programs Version D.0, P-00272 (10/17)). When a claim is for a drug purchased through the 340B Program, the Basis of Cost Determination field must contain a value of "8" (340B/Disproportionate Share Pricing/Public Health Service); in addition, there must be an appropriate corresponding Submission Clarification Code of "2" (Other Override) or "20" (340B). ForwardHealth will deny claims with Basis of Cost Determination and Submission Clarification Code values that do **not** correspond.

Professional Claim Modifier for Drugs Purchased Through the 340B Program

Professional claim formats require a "UD" modifier in order to identify claims for drugs purchased through the 340B Program. Providers who submit professional claims for physician-administered drugs purchased through the 340B Program to ForwardHealth are required to indicate modifier UD for each HCPCS (Healthcare Common Procedure Coding System) procedure code to indicate that the provider determined that the product being billed on the claim detail was purchased pursuant to rights available under Section 340B of the Public Health Act of 1992. ForwardHealth uses modifier UD to identify that a claim is for a physician-administered drug purchased through the 340B Program and to ensure that only eligible claims are being used to obtain drug manufacturer rebates. Providers should only submit claims for drugs purchased through the 340B Program if the provider is present on the HRSA 340B MEF.

ForwardHealth relies solely on modifier UD to identify professional claims for drugs purchased through the 340B Program. If modifier UD is present, then the claim will be excluded from the drug rebate invoicing process.

In addition, providers are required to submit their AAC when they submit claims for physician-administered drugs purchased through the 340B Program. Physician-administered drugs purchased through the 340B Program will be reimbursed at the lesser of the maximum allowable fee or the provider-submitted AAC.

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
- HIPPS (Health Insurance Prospective Payment System) 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 Wis. Admin. Code §§ DHS (Department of Health Services) 106.03(3) and 107.10, 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 transaction must include detail-level information for other insurance if they were processed at the detail level by the primary insurance.

Adjustments to Claims Submitted Prior to June 16, 2014

Providers who submit professional, institutional, or dental claim adjustments electronically on and after June 16, 2014, for claims

originally submitted prior to June 16, 2014, are required to submit other insurance information at the detail level on the adjustment if it was processed at the detail level by the primary insurance.

Topic #10837

Note Field for Most Claims Submitted Electronically

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

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

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

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

- Professional
- Institutional
- Dental

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

Claims Submitted via 837 Health Care Claim Transactions

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

Topic #561

Paper Claim Form Preparation and Data Alignment Requirements

Optical Character Recognition

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

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

Speed and Accuracy of Claims Processing

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

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

Handwritten Claims

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

Use Original Claim Forms

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

Use Laser or Ink Jet Printers

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

Alignment

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

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

The following sample claim forms demonstrate correct and incorrect alignment:

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

Clarity

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

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

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

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

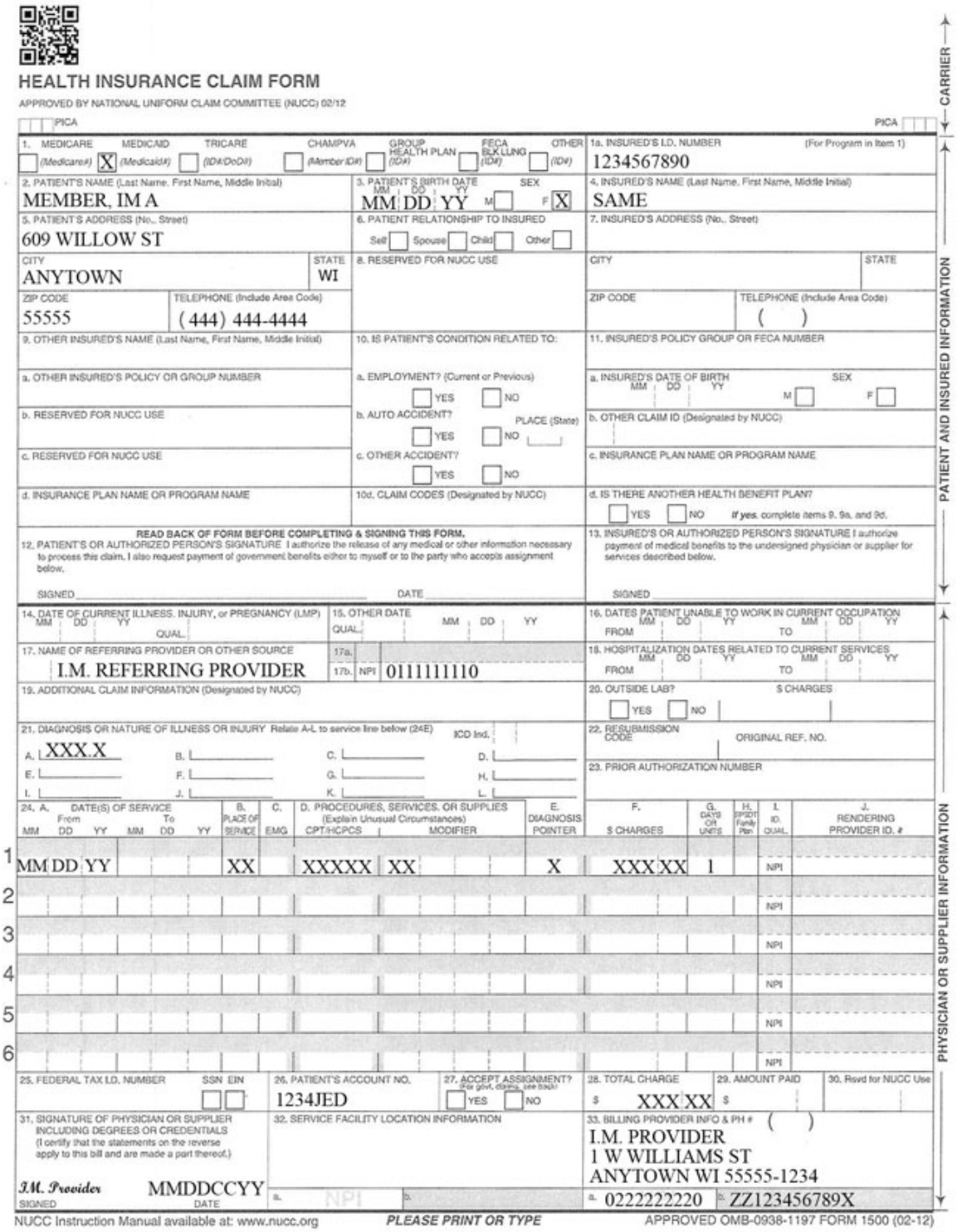
Staples, Correction Liquid, and Correction Tape

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

Additional Diagnosis Codes

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

Sample of a Correctly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

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

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

CITY: ANYTOWN STATE: WI

8. RESERVED FOR NUCC USE

CITY: STATE:

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

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

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

17a.

17b. NPI 0111111110

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. XXX.X B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

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

26. PATIENT'S ACCOUNT NO.: 1234JED

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

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

I.M. Provider MMDDCCYY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

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

a. 0222222220 b. ZZ123456789X

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

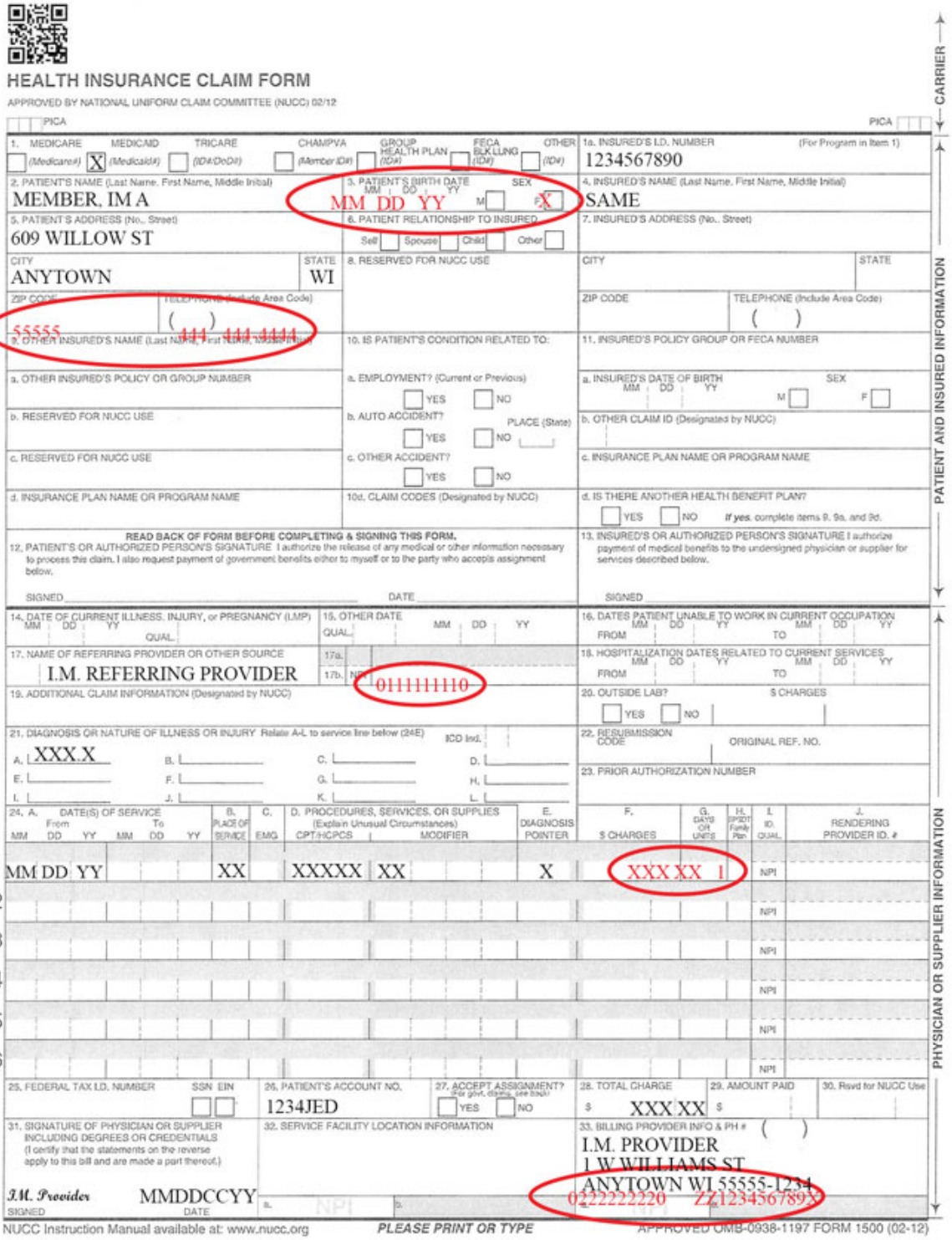
APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample of an Incorrectly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

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

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

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

CITY: ANYTOWN | STATE: WI

8. RESERVED FOR NUCC USE

CITY | STATE

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

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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SIGNED _____

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

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A. XXX.X B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

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

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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I.M. Provider MMDDCCYY

SIGNED DATE

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a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

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

CARRIER

PATIENT AND INSURED INFORMATION

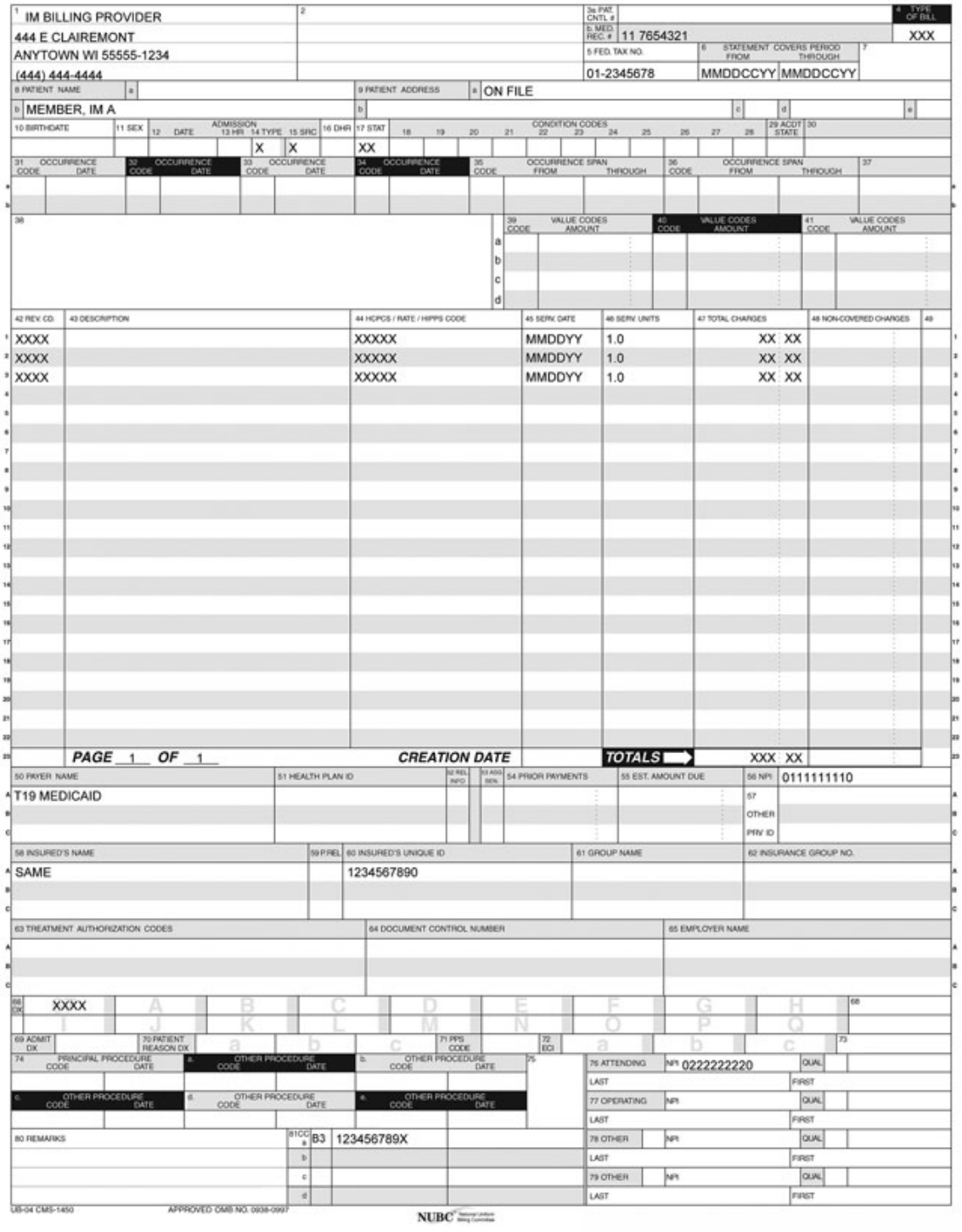
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

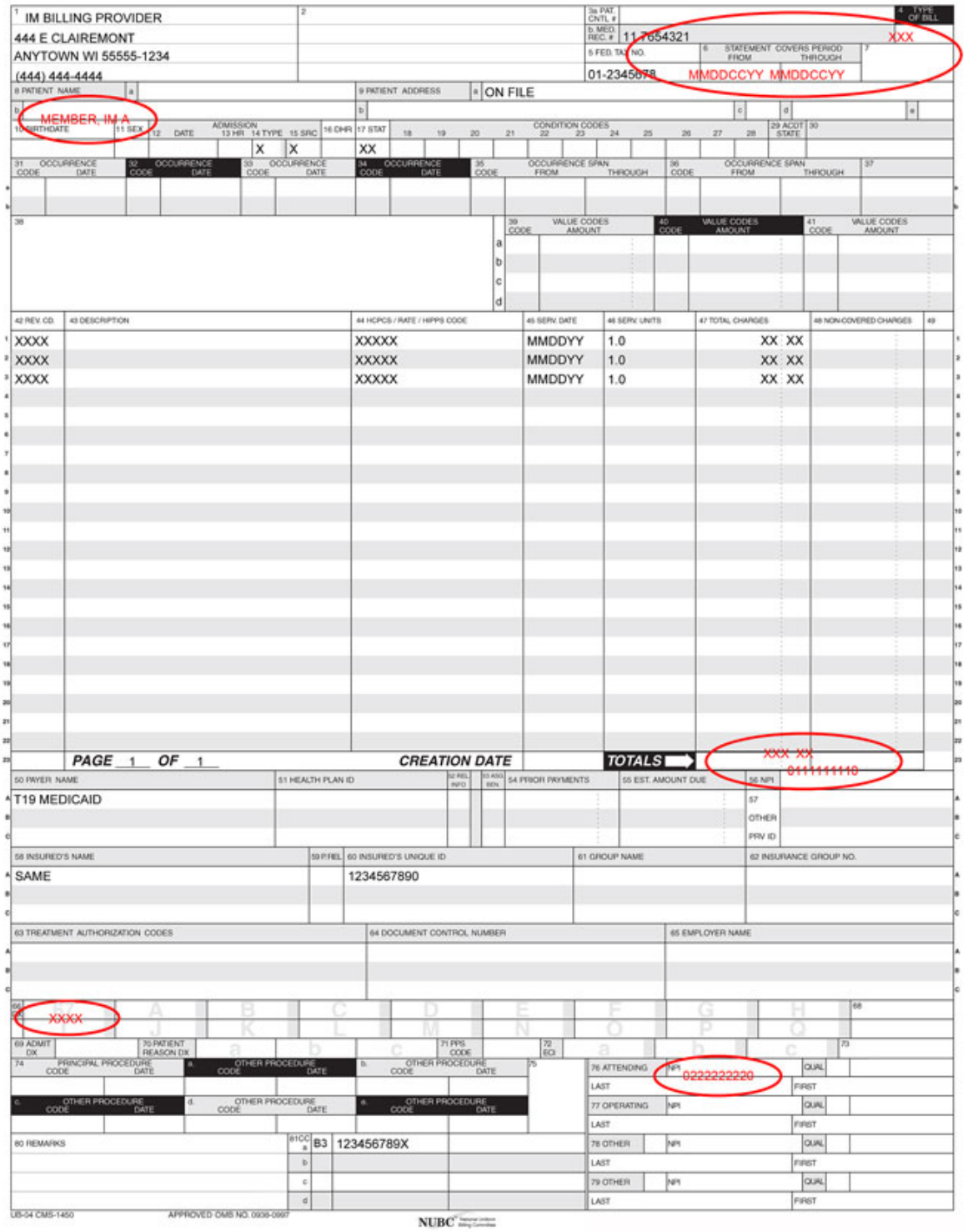
Sample of a Correctly Aligned UB-04 Claim Form



1 IM BILLING PROVIDER 444 E CLAIREMONT ANYTOWN WI 55555-1234 (444) 444-4444	4 TYPE OF BILL: XXX 3b MED REC #: 11 7654321 5 FED TAX NO.: 01-2345678 6 STATEMENT COVERS PERIOD: MMDDCCYY THROUGH MMDDCCYY
8 PATIENT NAME: MEMBER, IM A	9 PATIENT ADDRESS: ON FILE
10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE: X	15 SRC: X	16 DHR	17 STAT: XX
42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
XXXX		XXXXX	MMDDYY	1.0	XX XX	
XXXX		XXXXX	MMDDYY	1.0	XX XX	
XXXX		XXXXX	MMDDYY	1.0	XX XX	
PAGE 1 OF 1		CREATION DATE		TOTALS	XXX XX	
50 PAYER NAME	51 HEALTH PLAN ID	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI: 0111111110		
T19 MEDICAID				57 OTHER PRV ID		
58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.		
SAME		1234567890				
63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME				
66 DX: XXXX						
69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73		
74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75			
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE				
80 REMARKS	81CC a: B3 123456789X					
76 ATTENDING NPI: 0222222220 QUAL	LAST	FIRST				
77 OPERATING NPI QUAL	LAST	FIRST				
78 OTHER NPI QUAL	LAST	FIRST				
79 OTHER NPI QUAL	LAST	FIRST				

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC

Sample of an Incorrectly Aligned UB-04 Claim Form



Topic #22797

Payment Integrity Review Supporting Documentation

Providers are notified that an individual claim is subject to PIR (payment integrity review) through a message on the Portal when submitting claims. When this occurs, providers have seven calendar days to submit the supporting documentation that must be retained in the member's record for the specific service billed. This documentation must be attached to the claim. The following are examples of documentation providers may attach to the claim; however, this list is not exhaustive, and providers may submit any documentation available to substantiate payment:

- Case management or consultation notes
- Durable medical equipment or supply delivery receipts or proof of delivery and itemized invoices or bills
- Face-to-face encounter documentation
- Individualized plans of care and updates
- Initial or program assessments and questionnaires to indicate the start DOS (date of service)
- Office visit documentation
- Operative reports
- Prescriptions or test orders
- Session or service notice for each DOS
- Testing and lab results
- Transportation logs
- Treatment notes

Providers must attach this documentation to the claim at the time of, or up to seven days following, submission of the claim. A claim may be denied if the supporting documentation is not submitted. If a claim is denied, providers may submit a new claim with the required documentation for reconsideration. To reduce provider impact, claims reviewed by the OIG (Office of the Inspector General) will be processed as quickly as possible, with an expected average adjudication of 30 days.

Topic #1402

Provider Numbers

For the purposes of this Online Handbook topic, FQHC (federally qualified health center) refers to Tribal and Out-of-State FQHCs. This topic does not apply to Community Health Centers subject to PPS (Prospective Payment System) reimbursement.

Providers are required to indicate their FQHC 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 (04/2017)) form
- Noncompound Drug Claim (F-13072 (04/2017)) form

Exceptions to Paper Claim Reimbursement Reduction

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

- In-state emergency providers
- Out-of-state providers
- Medicare crossover claims
- Any claims that ForwardHealth requires additional supporting information to be submitted on paper, such as:
  - Hysterectomy claims must be submitted along with an Acknowledgment of Receipt of Hysterectomy Information (F-01160 (06/2013)) form
  - Sterilization claims must be submitted along with a paper Consent for Sterilization (F-01164 (10/2008)) form.
  - Claims submitted to Timely Filing appeals must be submitted on paper with a Timely Filing Appeals Request (F-13047 (08/2015)) form.
  - In certain circumstances, drug claims must be submitted on paper with a Pharmacy Special Handling Request (F-13074 (04/2014)) form.
  - Claims submitted with four or more NDCs (National Drug Codes) for compound and noncompound drugs with specific and non-specific HCPCS (Healthcare Common Procedure Coding System) procedure codes.

Topic #18197

Sleep Medicine Testing

Facility-Based Sleep Studies and Polysomnography

When submitting a professional claim to ForwardHealth for a facility-based sleep study or polysomnography, providers are reminded of the following:

- If less than six hours of testing were recorded, or if other reduced services were provided, modifier 52 (Reduced Services) must be indicated.
- It is not appropriate to bill twice for any single component of a sleep study.

Home-Based Sleep Studies

When submitting a professional claim to ForwardHealth for a home-based sleep study, providers are reminded of the following:

- If less than six hours of testing were recorded, or if other reduced services were provided, modifier 52 must be indicated.
- When billing for only the interpretation of a home-based sleep study, the code that was used for the technical service must be used with the POS (place of service) code for where the physician performed the interpretation, along with modifier 26 (Professional Component), to indicate that only the professional service was performed.
- When billing for only the technical portion of a home-based sleep study, the procedure code and POS are based on the physical location of the service. Modifier TC (Technical Component) must be included to indicate that only the technical services were performed.
- It is not appropriate to bill twice for any single component of a sleep study.

Topic #23078

Claims Submission for Beyfortus

Beyfortus (nirsevimab), a monoclonal antibody, is used for the prevention of lower respiratory tract disease caused by RSV (respiratory syncytial virus) in infants or children.

Claims for Beyfortus must be submitted on professional claims.

On claims for Beyfortus, providers are required to indicate the applicable CPT (Current Procedural Terminology) procedure code listed in the following table with a zero-billed amount for the Beyfortus product administered. Providers must also include the **SL** modifier (State supplied vaccine) with the applicable CPT procedure code for Beyfortus obtained through the VFC (Vaccines for Children) Program.

Procedure Codes for Beyfortus
90380 (Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use)
90381 (Respiratory syncytial virus, monoclonal antibody, seasonal dose; 1 mL dosage, for intramuscular use)

To receive reimbursement for the administration of Beyfortus, providers must also indicate **one** of the following CPT administration codes on claims submitted to ForwardHealth:

- **96380** (Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection, with counseling by physician or other qualified health care professional)
- **96381** (Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection)

Providers may refer to the interactive maximum allowable fee schedules on the ForwardHealth Portal.

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 From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	N460574411101 ME100															
	11	13	14	11	13	14	11		90378	KP	AC	500 00	2	N	NPI	0123456789
2	N460574411201 ME50															
	11	13	14	11	13	14	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 From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	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 physician-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.

Responses

Topic #13437

ForwardHealth-Initiated Claim Adjustments

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

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

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

Topic #11537

National Correct Coding Initiative

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

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

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

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

Medically Unlikely Detail Edits

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

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

Procedure-to-Procedure Detail Edits

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

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

Quarterly Code List Updates

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

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

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

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

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

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

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.

Responsibilities

Topic #22798

Payment Integrity Review Program

The PIR (Payment Integrity Review) program:

- Allows the OIG (Office of the Inspector General) to review claims prior to payment.
- Requires providers to submit all required documentation to support approval and payment of PIR-selected claims.

The goal of the PIR program is to further safeguard the integrity of Wisconsin DHS (Department of Health Services)-administered public assistance programs, such as BadgerCare Plus and Wisconsin Medicaid, from fraud, waste, and abuse by:

- Proactively reviewing claims prior to payment to ensure federal and state requirements are met.
- Providing enhanced, compliance-based technical assistance to meet the specific needs of providers.
- Increasing the monitoring of benefit and service areas that are at high risk for fraud, waste, and abuse.

Fraud, waste, and abuse includes the potential overutilization of services or other practices that directly or indirectly result in unnecessary program costs, such as:

- Billing for items or services that were not rendered.
- Incorrect or excessive billing of CPT (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) procedure codes.
- Unit errors, duplicate charges, and redundant charges.
- Billing for services outside of the provider specialty.
- Insufficient documentation in the medical record to support the charges billed.
- Lack of medical necessity or noncovered services.

Note: Review of claims in the PIR process does not preclude claims from future post-payment audits or review.

Payment Integrity Review Program Overview

When a provider submits a claim electronically via the ForwardHealth Portal, the system will display a message if the claim is subject to PIR. The message will instruct providers to submit supporting documentation with the claim. Providers have seven days to attach documentation to claims. The claim will automatically be denied if documentation is not attached within seven days.

Claims that meet PIR requirements may be eligible for payment once they are accurate and complete. Claims that do not meet PIR requirements may be denied or repriced. In these cases, providers are encouraged to:

- Review the EOB (Explanation of Benefits) for billing errors.
- Refer to the Online Handbook for claims documentation and program policy requirements.
- Correct the PIR billing errors and resubmit the claim.

Types of Payment Integrity Review

There are three types of review in the PIR program:

- Claims Review

- Pre-Payment Review
- Intermediate Sanctions

For each type of review, providers must submit supporting documentation that substantiates the CPT and/or HCPCS procedure codes on the claim.

	Claims Review	Pre-Payment Review	Intermediate Sanction
How claims are selected for review	A sampling of claims is selected from providers, provider types, benefit areas, or service codes identified by the OIG.	The OIG has reasonable suspicion that a provider is violating program rules.	The OIG has established cause that a provider is violating program rules.
How providers are notified that selected claims are under review	The provider receives a message on the Portal.	The provider receives a Provider Notification letter and message on the Portal.	The provider receives a Notice of Intermediate Sanction letter and message on the Portal.
How to successfully exit the review	Claims are selected for review based on a pre-determined percentage of claim submissions of specific criteria. All providers who bill the service codes that are part of this criteria are subject to review, regardless of their compliance rates.	75 percent of a provider's reviewed claims over a three-month period must be paid as submitted. The number of claims submitted during the three-month period may not drop more than 10 percent of the provider's volume of submitted claims prior to pre-payment review.	The provider must meet parameters set during the sanction process.

Claims Review

In accordance with Wis. Admin. Code § DHS 107.02(2), the OIG may identify providers, provider types, benefit areas, or procedure codes, and based on those criteria, choose a sampling of claims to review prior to payment. When a claim submitted through the Portal that meets one of these criteria is selected for review, a message will appear on the Portal to notify the provider that the claim must be submitted with all necessary supporting documentation within seven calendar days. The claim will automatically be denied if documentation is not attached within seven days.

Pre-Payment Review

In accordance with Wis. Admin Code § DHS 106.11, if the OIG has cause to suspect that a provider is prescribing or providing services that are not necessary for members, are in excess of the medical needs of members, or do not conform to applicable professional practice standards, the provider's claims may be subject to review prior to payment. Providers who are subject to this type of review will receive a Pre-Payment Review Initial Notice letter, explaining that the OIG has identified billing practice or program integrity concerns in the provider's claims that warrant the review. This notice details the steps the provider must follow to substantiate their claims and the length of time their claims will be subject to review. Additionally, a message will appear on the Portal when the provider submits claims to notify the provider that certain claims must be submitted with all necessary supporting documentation within seven calendar days. The claim will automatically be denied if documentation is not attached within seven days.

For a provider to be considered for removal from pre-payment review, both of the following conditions must be met:

- 75 percent of the provider's reviewed claims over a three-month period are approved to be paid.
- The number of claims the provider submits during that three-month period may not drop more than 10 percent from their submitted claim amount prior to pre-payment review.

The OIG reserves the right to adjust these thresholds according to the facts of the case.

Intermediate Sanction Review

In accordance with Wis. Admin. Code § DHS 106.08(3)(d), if the OIG has established cause that a provider is violating program rules, the OIG may impose an intermediate sanction that requires the provider's claims to be reviewed prior to payment. Providers who are subject to this type of review will be sent an official Intermediate Sanction Notice letter from the OIG that details the program integrity concerns that warrant the sanction, the length of time the sanction will apply, and the provider's right to appeal the sanction. The provider also will receive a message on the Portal when submitting claims that indicates certain claims must be submitted with the necessary supporting documentation within seven calendar days. The claim will automatically be denied if documentation is not attached within seven days.

For a provider to be considered for removal from an intermediate sanction, the provider must meet the parameters set during the sanction process.

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.

Reimbursement

5

Archive Date:04/01/2024

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 can revert back to receiving paper checks by disenrolling in EFT.
- Organizations may change their EFT information at any time.
- Organizations will continue to receive their Remittance Advice as they do currently.

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

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

Recoupment and Reversals

Enrollment in EFT does not change the current process of recouping funds. Overpayments and recoupment of funds will continue

to be conducted through the reduction of payments.

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

For the purposes of this Online Handbook topic, FQHC (federally qualified health center) refers to Tribal and Out-of-State FQHCs. This document does not apply to Community Health Centers subject to PPS (Prospective Payment System) reimbursement.

All cost reports are audited. Once a cost report has been audited, an FQHC has 30 days to request an adjustment. After 30 days, the cost report is final and additional encounters (that is, 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 Worksheets

For the purposes of this Online Handbook topic, FQHC (federally qualified health center) refers to Tribal and Out-of-State FQHCs. This document does not apply to Community Health Centers subject to PPS (Prospective Payment System) reimbursement.

FQHCs are required to use the Tribal and Out-of-State Federally Qualified Health Center Cost Report Forms (F-11129B-H (01/2021)) for cost settlements.

The tribal and out-of-state FQHC cost report worksheets 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

For the purposes of this Online Handbook topic, FQHC (federally qualified health center) refers to Tribal and Out-of-State FQHCs. This document does not apply to Community Health Centers subject to PPS (Prospective Payment System) reimbursement.

FQHCs interested in receiving a partial cost settlement for services rendered to members for a given fiscal year may submit an interim report to the Wisconsin DMS (Division of Medicaid Services) OIG (Office of the Inspector General). Interim reports may be submitted for activity occurring within the FQHC's fiscal year at any time until the FQHC's cost report is audited by OIG, which occurs one to five years following the end of the FQHC's fiscal year.

The Tribal and Out-of-State Federally Qualified Health Center Interim Report (F-11130 (01/2021)) is available in fillable Microsoft Excel format.

Topic #22077

Outstationed Enrollment for Tribal Federally Qualified Health Centers

For the purposes of this Online Handbook topic, FQHC (federally qualified health center) refers to Tribal and Out-of-State FQHCs. This document does not apply to Community Health Centers subject to PPS (Prospective Payment System) reimbursement.

Following the end of the FQHC's fiscal year, the FQHC will complete and submit to OIG the Federally Qualified Health Center Outstationed Enrollment Survey form (F-02758 (01/2021)). The FQHC should submit the form with the cost report under the same timeline.

Through the reconciliation process, Medicaid payments associated with oustationed enrollment will equal 100 percent of FQHC allowable outstationed enrollment expenditures.

Topic #4172

Site of Service Codes as Allowable Encounters

For the purposes of this Online Handbook topic, FQHC (federally qualified health center) refers to Tribal and Out-of-State FQHCs. This document does not apply to Community Health Centers subject to PPS (Prospective Payment System) reimbursement.

Site of service revenue codes received by ForwardHealth on Medicare crossover claims may be considered an allowable encounter on FQHC 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 (skilled nursing facility)
0525	Visit by RHC/FQHC practitioner to a member in an SNF (not in a covered Part A stay) or NF (nursing facility) or ICF MR (Intermediate Care Facilities for Individuals with Mental Retardation) or other residential facility
0528	Visit by RHC/FQHC practitioner to other non-RHC/FQHC site (for example, 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

For the purposes of this Online Handbook topic, FQHC (federally qualified health center) refers to Tribal and Out-of-State FQHCs. This document does not apply to Community Health Centers subject to PPS (Prospective Payment System) reimbursement.

FQHCs 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 (that is, cost settlements) that equal 100 percent of reasonable costs. Claims for FQHC services that are **not** submitted with an FQHC provider number may not be included on cost reports and, therefore, will not be included in the cost settlement.

Services provided to BadgerCare Plus and Medicaid members are eligible for inclusion on cost reports.

Deadline

Because providers are required to retain documentation for no less than five years under Wis. Admin. Code § DHS 106.02(9)(e)2, 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 Wisconsin DMS (Division of Medicaid Services) OIG (Office of the Inspector General) 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 FQHC 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 FQHC. To be compliant with the BIPA requirements and for a cost settlement to be issued from ForwardHealth, cost reports must be filed with OIG.

Interim Payments

If ForwardHealth does not receive a cost report from an FQHC for two fiscal years, Wisconsin Medicaid may withhold future interim FQHC payments. If an FQHC submits a cost report to OIG more than five years after the DOS, ForwardHealth will not accept the report and may recoup any interim payments made to the FQHC for that reporting period.

Member Information

6

Archive Date:04/01/2024

Member Information:Enrollment Categories

Topic #16677

BadgerCare Plus Benefit Plan Changes

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

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

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

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

Topic #18777

Real-Time Eligibility Determinations

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

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

Eligibility Verification

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

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

Sample Temporary Identification Card for Badger Care Plus

To the Provider

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

NOTE:

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

WISCONSIN DEPARTMENT OF HEALTH SERVICES

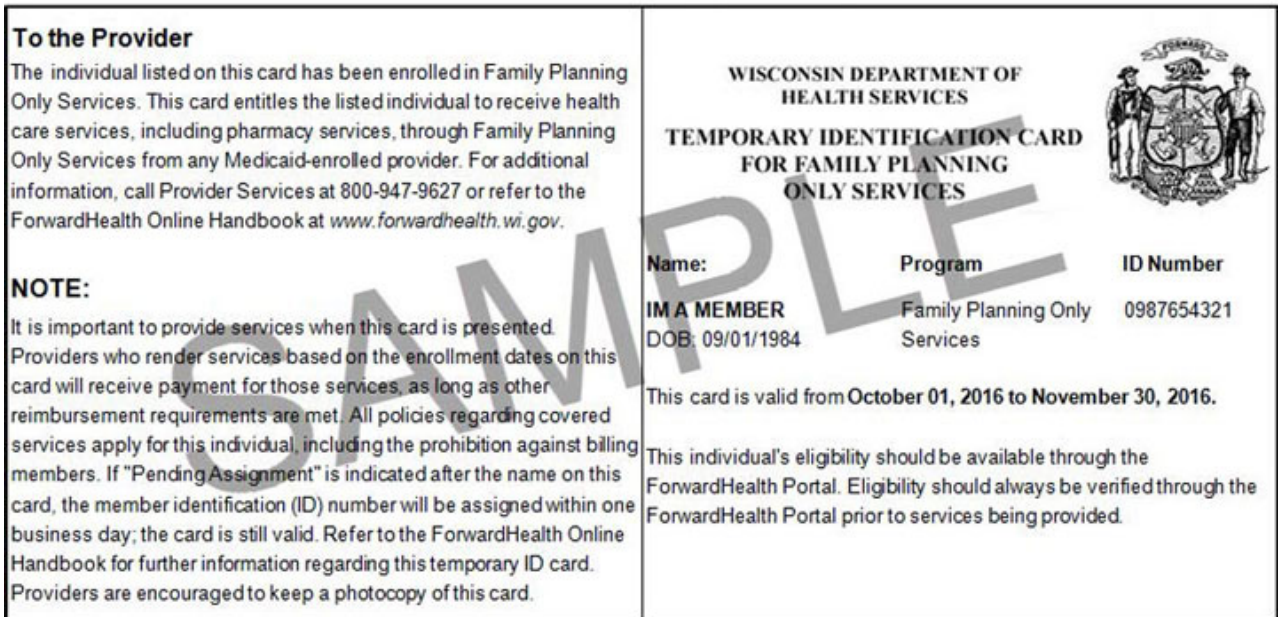
TEMPORARY IDENTIFICATION CARD FOR BADGERCARE PLUS

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

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

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

Sample Temporary Identification Card for Family Planning Only Services



To the Provider

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

NOTE:

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

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR FAMILY PLANNING ONLY SERVICES

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

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

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

Coordination of Benefits

7

Archive Date:04/01/2024

Coordination of Benefits:Commercial Health Insurance

Topic #18497

Explanation of Medical Benefits Form Requirement

An Explanation of Medical Benefits (F-01234 (04/2018)) form must be included for each other payer when other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) sources are indicated on a paper claim or paper adjustment.

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

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

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

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

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

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

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

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

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

Resources

8

Archive Date:04/01/2024

Resources:WiCall

Topic #6257

Entering Letters into WiCall

For some WiCall inquries, health care providers are required to enter their taxonomy code with their NPI (National Provider Identifier). Because taxonomy codes are a combination of numbers and letters, telephone key pad combinations, shown in the table below, allow providers to successfully enter taxonomy code letters for WiCall functions (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 financial payer (program, i.e., Wisconsin Medicaid, WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)) and entering their provider ID, member identification number, DOS (date of service), and the amount billed.

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

Enrollment Verification

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

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

PA Status

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

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

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

Electronic Data Interchange

Topic #461

Electronic Data Interchange Helpdesk

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

Providers with policy questions should call Provider Services.

Enrollment Verification

Topic #469

An Overview

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

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

Topic #4903

Copay Information

No Copay

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

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

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

Copay

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

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

Non-Emergent Copay

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

- The name of the benefit plan

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

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

Topic #4901

Enrollment Verification on the Portal

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

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

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

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

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

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

Topic #4900

Entering Dates of Service

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

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

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

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

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

Topic #4899

Member Identification Card Does Not Guarantee Enrollment

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

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

Topic #4898

Responses Are Based on Financial Payer

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

There are three financial payers under ForwardHealth:

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

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

Contact Information

Topic #4456

Resources Reference Guide

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

ForwardHealth Portal	**www.forwardhealth.wi.gov/**	**24 hours a day, seven days a week**
Public and secure access to ForwardHealth information with direct link to contact Provider Services for up-to-date access to ForwardHealth programs information, including publications, fee schedules, and forms.		
WiCall Automated Voice Response System	**800-947-3544**	**24 hours a day, seven days a week**
WiCall, the ForwardHealth AVR (Automated Voice Response) system, provides responses to the following inquiries: - Checkwrite - Claim status - PA (prior authorization) - Member enrollment		
ForwardHealth Provider Services Call Center	**800-947-9627**	**Call center representatives: Monday through Friday, 7 a.m. to 6 p.m. (Central time)* Virtual agent: 24 hours a day, seven days a week**
To assist providers in the following programs: - BadgerCare Plus - Medicaid - SeniorCare - ADAP (Wisconsin AIDS Drug Assistance Program) - WCDP (Wisconsin Chronic Disease Program) - Wisconsin Medicaid and BadgerCare Plus Managed Care Programs - Wisconsin Well Woman Medicaid - WWWP (Wisconsin Well Woman Program)		
ForwardHealth Portal Helpdesk	**866-908-1363**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central time)***
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal accounts, registrations, passwords, and submissions through the Portal.		

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

*With the exception of state-observed holidays.

Portal

Topic #4743

Acute and Primary Managed Care Portal

Information and Functions Through the Portal

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

The following information is available through the Portal:

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

Topic #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 #4345

Creating a Provider Account

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

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

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

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

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

Topic #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:

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

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

Topic #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 #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 email). Provider Services will respond to the inquiry by the preferred method of response indicated within five business days.

Topic #4400

Internet Connection Speed

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

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

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

Topic #4351

Logging in to the Provider Area of the Portal

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

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

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

Topic #5158

Managed Care Organization Portal Reports

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

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

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

Capitation Payment Listing Report

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

Initial Enrollment Roster Report

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

Final Enrollment Roster Report

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

Other Reports

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

Topic #4744

Members ForwardHealth Portal

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

Topic #4344

Obtaining a Personal Identification Number

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

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

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

Providers may request a PIN by following these steps:

1. Go to the Portal.
2. Click 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, they have complete access to all functions within the specific secure area of their Portal and are permitted to add, remove, and manage other individual roles.

Add Backup Contact Information for Provider Administrator Accounts

Provider administrators must set up a backup contact for their Portal accounts to ensure that requests and changes can be verified as legitimate. Provider administrators will not be able to use the same contact information for both the administrator account and the backup contact.

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 assist in daily business activities with ForwardHealth programs.

Interactive Maximum Allowable Fee Schedule

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

ForwardHealth Communications

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

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

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

Trainings

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

Contacting Provider Services

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

Online Enrollment

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

Other Resources Available on the Portal

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

- A "What's New?" section for providers that links to the latest information posted to the Provider area of the Portal
- Home page for the provider (Providers have administrative control over their Portal homepage and can grant other employees access to specified areas of the Portal, such as claims and PA.)

- Email subscription service for Updates (Providers can register for email subscription to receive notifications of new provider publications via email. Users are able to select, by program and service area, which publication notifications they would like to receive.)
- A forms library

Topic #4741

Secure Area of the Provider Portal

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

Claims and Adjustments Using the Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, and determine what claims are in "pay" status on the Portal. Providers can search for and view the status of all of their finalized claims, regardless of how they were submitted (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 PA and Amendment Requests Via the Portal

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

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

Electronic Communications

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

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

Enrollment Verification

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

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

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

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

Other Business Enhancements Available on the Portal

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

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

Topic #4401

System and Browser Requirements

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

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

Topic #4742

Trading Partner Portal

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

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

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

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

Training Opportunities

Topic #12757

Training Opportunities

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

On-Site Sessions

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

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

Online (Real-Time, Web-Based) Sessions

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

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

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

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

Recorded Webcasts

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

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

Notification of Training Opportunities

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

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

Managed Care

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Archive Date:04/01/2024

Managed Care:Managed Care Information

Topic #16177

Care4Kids Program Overview

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

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

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

Program Administration

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

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

Member Enrollment Verification

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

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

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

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

Contact Information

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

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

Covered and Noncovered Services

Topic #16197

Care4Kids Program Benefit Package

Covered Services

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

Noncovered Services

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

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

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

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

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

Promoting Interoperability Program

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Archive Date:04/01/2024

Promoting Interoperability Program: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 PI (Promoting Interoperability) Incentive Program Appeal" on the secure Portal homepage.

Eligible Professionals and Hospitals (or an authorized preparer) filing a Wisconsin Medicaid PI 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, phone number, email address, and the preferred method of contact of the person submitting the appeal (that is, the Eligible Hospital, Eligible Professional, or authorized preparer)

Once the Wisconsin Medicaid PI 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 PI Program cannot match the NPI supplied with a current application, the Eligible Professional or Hospital will receive the following message: "A Wisconsin Medicaid PI 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 email confirming the receipt of the appeal request and a second email confirming that the appeal request has been adjudicated. The Wisconsin Medicaid PI Program will communicate the appeal determination through a decision letter, sent to the address provided during Wisconsin Medicaid PI 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 may only appeal to the Wisconsin Medicaid PI (Promoting Interoperability) Program for the following

reasons:

- To dispute the payment amount
- To appeal a denied Wisconsin Medicaid PI Program application

Appealing a Payment Amount

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

Appealing a Denied Wisconsin Medicaid Promoting Interoperability Program Application

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

Eligible Professionals 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 may be required to upload based on the type of appeal, including instances when a statement is needed from the Eligible Professional in the appeals application free-form comment box
- Appealing the payment amount

Denied Application Appeals		
Reason for Appeal	**Explanation**	**Documentation Required**
Patient Volume	The provider was denied approval for not meeting the patient volume requirement during the 90-day reporting timeframe but believes they met the appropriate patient volume requirement.	Provide the patient volume for the reported 90-day period on the Wisconsin Medicaid PI Program application.
Sanctioned by Medicare or Medicaid	The provider was denied for having current or pending sanctions with Medicare or Medicaid but does not have any sanctions.	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 PI Program application, provide a clarifying statement that the Eligible Professional has no current or pending sanctions with Medicare or Medicaid.
Demonstration of AIU (Adopting, Implementing, and Upgrading)	The provider was denied for failing to meet the AIU requirements but believes they met the AIU requirements.	Provide a statement explaining how AIU requirements were met. Include documentation supporting the adoption, implementation, or upgrade of certified EHR (electronic health record) technology.
Demonstration of	The provider was denied for failing to meet	Provide a statement explaining how Meaningful Use

Meaningful Use	Meaningful Use requirements for the reporting period specified but believes they did meet Meaningful Use requirements.	requirements were met. Include documentation to support the satisfaction of the Meaningful Use measure (s) in question.
Duplicate Payment	The provider was denied due to a history of prior payments for the specified program year but has not received any prior payments from the Wisconsin Medicaid PI Program, the Medicare PI Program, or the PI Program of another state.	Eligible Professionals may only receive one incentive payment for a given program year. The Eligible Professional must submit a copy of their full incentive payment history as reported on the CMS (Centers for Medicare & Medicaid Services) Promoting Interoperability Programs Registration System.
Eligible Provider and Specialty Type	The provider was denied due to not meeting the eligible provider type requirement but believes their scope of practice falls under the eligible provider types.	To qualify for a Wisconsin Medicaid PI payment, Eligible Professionals must be one of the provider types and specialties indicated within the SMHP (State Medicaid Health IT Plan), Section 3—Program Administration and Oversight, subsection 1.4. The Eligible Professional must submit evidence that they are one of the provider type and specialty combinations allowed per the SMHP.
Hospital Based	The Eligible Professional was denied for being hospital based but believes they meet the requirement of providing less than 90 percent of their services in an inpatient hospital or emergency department or of funding the acquisition, implementation, and maintenance of CEHRT (Certified Electronic Health Record Technology) without reimbursement from a hospital.	Eligible Professionals are not eligible for the Wisconsin Medicaid PI 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 PI Program application, provide a clarifying statement that the Eligible Professional is not hospital based.

Payment Amount Appeals		
Reason for Appeal	**Explanation**	**Documentation Required**
Pediatrician Reduced Payment Amount Applied Incorrectly	Pediatricians received reduced payment because they were deemed to have met the reduced Medicaid patient volume criteria (20 percent) by the Wisconsin Medicaid PI Program, but the Eligible Professional believes that they have fulfilled the 30 percent Medicaid patient volume requirement.	Provide the patient volume numbers for the reported 90-day period that should have been reported on the original Wisconsin Medicaid PI Program application.

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 by ONC (Office of the National Coordinator for Health Information Technology), 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 objectives and measures to which they are attesting for the applicable stage of Meaningful Use unless an exclusion applies

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

In Program Year 2019 and subsequent Program Years, all Eligible Professionals are required to use technology certified to the 2015 Edition.

Documentation Requirements

The Wisconsin Medicaid PI (Promoting Interoperability) Program requires Eligible Professionals to submit documentation indicating the acquisition or use of EHR technology certified to the current federal standards during the Program Year in order to demonstrate a business relationship between an Eligible Professional's place of work and their EHR vendor. All Eligible Professionals, regardless of their year of participation, will be required to submit at least one of the following with their Wisconsin Medicaid PI Program application to document their acquisition of 2015 Edition CEHRT:

- Contract
- Lease
- Proof of purchase
- Receipt
- Signed and dated vendor letter

All of the following must be identified on the submitted documentation, regardless of format:

- Vendor
- Product
- Product version number

Eligible Professionals are required to retain supporting documentation for their Wisconsin Medicaid PI Program application for six years post-attestation.

Submission Requirements

Individual Eligible Professionals are required to upload to the Wisconsin Medicaid PI Program application. Organizations attesting on behalf of **more than one** Eligible Professional may either upload the CEHRT documentation to each application or submit the documentation once, via secure email, with a list of all Eligible Professionals to whom the documentation applies.

Uploading Documentation

Organizations that are uploading supporting documentation are required to upload it through the Application Submission (Part 1 of 2) page in the Submit section of the Wisconsin Medicaid PI Program application. Organizations are strongly encouraged to upload their supporting documentation as a Microsoft Excel spreadsheet, although Microsoft Word, and PDF files can also be uploaded. All uploaded files must be two megabytes or less. For specific instructions on uploading supporting documentation, refer to the Wisconsin Medicaid Promoting Interoperability Program User Guide for Eligible Professionals on the User Guides page.

Emailing Documentation

If submitting supporting documentation via email, Eligible Professionals are required to do the following:

- To ensure documentation is applied to the appropriate application, identify the organization name to which the documentation is applicable within the body of the email.
- Encrypt all confidential information.
- Attach the CEHRT documentation to the email.
- Indicate the following as the subject line of the email: "Eligible Professional Application Supporting Documentation."
- Attach the rest of the required documentation to the email before sending it to the Wisconsin Medicaid PI Program at DHSPromotingInteroperabilityProgram@dhs.wisconsin.gov.

Eligible Professionals are encouraged to send their CEHRT, patient volume, and Meaningful Use measure documentation in a single email.

Topic #12037

Overview of the Promoting Interoperability Program

The PI (Promoting Interoperability) 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 American Recovery and Reinvestment Act of 2009, Medicare and Medicaid have separate PI programs. All Eligible Professionals must be Wisconsin Medicaid-enrolled in order to participate in the Wisconsin Medicaid PI Program in a given Program Year. Eligible Professionals may participate in only one state's Medicaid PI Program. Eligible Professionals should apply for EHR (electronic health record) payments from the state with which they do most of their business.

Eligible Professionals must first register through the CMS (Centers for Medicare & Medicaid Services) R&A (Medicare and Medicaid PI Program Registration and Attestation System) system. Eligible Professionals may then apply with the Wisconsin Medicaid PI Program. All Wisconsin Medicaid PI 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. Participating Eligible Professionals may receive an incentive payment once per calendar year.

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

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

- First payment year: Eligible Professionals can apply for incentive payments for adopting, implementing, upgrading, demonstrating Meaningful Use of 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 either a 90-day period or the full calendar year depending on the stage of Meaningful use to which they attest and the Program Year of that attestation.

Eligible Professionals are not required to participate in consecutive years of the Wisconsin Medicaid PI Program. For example, an Eligible Professional may have registered and completed all requirements for their first year in 2011 and received a payment but then waited until 2013 to demonstrate Meaningful Use during a 90-day, continuous period for the second payment year.

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

Note: Emails from the Wisconsin Medicaid PI Program are to the contact person provided during the Medicare and Medicaid PI Program Registration and Attestation System process. The name indicated in the "From" line for these emails is DHSPromotingInteroperabilityProgram@dhs.wisconsin.gov.

Resources for Promoting Interoperability Program

Topic #18097

Technical Assistance Services

Technical assistance services are available to all Medicaid-enrolled providers (including specialists) who are eligible to participate in or who already participate in the Medicaid or Medicare PI (Promoting Interoperability) Program. These services are designed to help providers as they adopt, implement, upgrade, and meaningfully use CEHRT (Certified Electronic Health Record Technology); they include the following:

- EHR selection and implementation guidelines
- Meaningful Use education and consulting, including readiness assessments and audit preparation
- Public health objective onboarding and testing assistance
- HIPAA (Health Insurance Portability and Accountability Act of 1996) security risk assessments
- Workflow optimization

The technical assistance services are being offered by the Health IT Extension Program, which is supported by MetaStar, Inc., an independent nonprofit quality improvement organization. For more information regarding the technical assistance services offered by the Health IT Extension Program, providers may email MetaStar, Inc., at **info@metastar.com**.

Financial Information

Topic #12120

835 Health Care Claim Payment/Advice Transaction

To assist trading partners in identifying Wisconsin Medicaid PI (Promoting Interoperability) 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 PI 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 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 PI (Promoting Interoperability) Program beginning in 2011 and up until 2016.

Wisconsin Medicaid Eligible Professionals*						
Calendar Year	**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 PI (Promoting Interoperability) 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.

Patient Volume

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 PI (Promoting Interoperability) 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 their 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 PI Program. Additionally, all Eligible Professionals included in the group practice who register for the Wisconsin Medicaid PI 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 their needy individual patient volume at an individual level and assign payment to the group practice. Conversely, an

Eligible Professional may calculate their needy individual patient volume at a group practice level and assign payment to themselves.

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 PI Program application.

Topic #12098

Eligible Member Patient Volume

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 is attributed to eligible members over a continuous 90-day period in the calendar year preceding the payment year or during the 12 months prior to the date of attestation.
- 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 PI (Promoting Interoperability) 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.

Definition of Eligible Members

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 PI Program defines eligible members as those members enrolled in the programs.

Definition of Patient Encounter

An eligible member patient encounter is defined as services rendered on any one day to an individual enrolled in a Medicaid program, regardless of the Medicaid reimbursement amount. Unpaid encounters for services rendered to an individual enrolled in a Medicaid program may be counted as eligible member patient encounters. Claims denied because the patient was not Medicaid eligible at the date of service cannot be counted as eligible member patient encounters.

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.

Standard Deduction

The federal regulations governing the Medicaid PI Program stipulate that an eligible member is an individual whose services are reimbursed through Medicaid (Title XIX). Since ForwardHealth is funded by both Medicaid (Title XIX) and the CHIP (Children's Health Insurance Program) (Title XXI), Eligible Professionals may be unable to distinguish encounters with eligible members from encounters with non-eligible members when determining their patient volume. To assist Eligible Professionals in determining their eligible patient encounters, the Wisconsin Medicaid PI Program will calculate a standard deduction.

The standard deduction for Program Year **2020** is 4.41 percent. To calculate eligible patient encounters, Eligible Professionals should multiply the total number of eligible member encounters by a factor of (1 - 0.0441), which is 0.9559, divide that number by the total number of patient encounters, and then multiply by 100 to convert it to a percentage. The final number should be rounded to the nearest whole number (for example, .01 through .49 should be rounded down to the nearest whole number, and .50 through .99 should be rounded up to the nearest whole number).

The standard deduction for Program Year **2021** is 4.47 percent. To calculate eligible member patient encounters, Eligible Professionals should multiply the total number of eligible member encounters by a factor of (1 - 0.0447), which is 0.9553, divide that number by the total number of patient encounters, and then multiply by 100 to convert it to a percentage.

Individual and Group Practice Methodologies

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 PI Program. Additionally, all Eligible Professionals included in the group practice who register for the Wisconsin Medicaid PI 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 group practice's 90-day period patient volume reporting period.
- 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 PI 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 practitioners within the group practice, regardless of provider type or eligibility status for the Wisconsin Medicaid PI (Promoting Interoperability) Program. Groups are defined by how their businesses are enumerated under their NPI (National Provider Identifier).

The standard deduction for Program Year **2020** is 4.41 percent. To figure out the eligible member patient encounters, Eligible Professionals must multiply their total eligible member encounter group practice patient volume by a factor of (1 - 0.0441), which is 0.9559, divide that number by their total eligible member group practice patient encounter volume, and then multiply by 100 to convert it to a percentage.

The standard deduction for Program Year **2021** is 4.47 percent. To figure out the eligible member patient encounters, Eligible Professionals must multiply their total eligible member encounter group practice patient volume by a factor of (1 - 0.0447), which is 0.9553, divide that number by their total eligible member group practice patient encounter volume, and then multiply by 100 to convert it to a percentage.

The following is an example of calculating group practice volume for the purpose of establishing eligibility for the Wisconsin Medicaid PI 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	RN (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 - 0.0447 = 0.9553) to the number of eligible members.

455 * 0.9553 = 434.6615

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

434.6615 / 1300 = 0.334355 or 33.44 percent

Therefore, the group practice patient volume is 33.44 percent, which is rounded to the nearest whole number of 33 percent, and is eligible for the Wisconsin Medicaid PI 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 they did not render services to at least one eligible member during the 90-day period; however, if the physician is new to practicing medicine (for example, a recent graduate of an appropriate training program), they would be eligible for the program because they do not need to provide proof of an encounter.

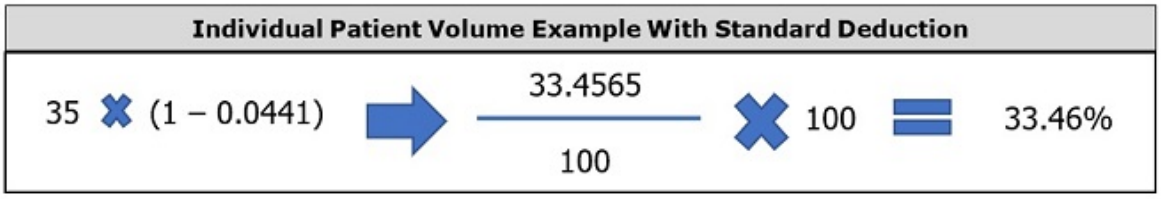
Topic #12100

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 their 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 PI (Promoting Interoperability) Program only considers services provided to members who are eligible to be reimbursed with funding directly from Medicaid (Title XIX) to be patient encounters. 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 PI Program will calculate a standard deduction.

The standard deduction for Program Year **2020** is 4.41 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 - 0.0441), which is 0.9559, divide that number by their total eligible member patient encounter volume, and then multiply by 100 to convert it to a percentage.



So the final eligible member patient encounter volume is 33.4565 encounters out of 100 total, or 33.46 percent, rounded to the nearest whole number, 33 percent.

Therefore, 33 percent of the Eligible Professional's patient volume is eligible members and the Eligible Professional fulfills the patient volume requirement for the Wisconsin Medicaid PI Program. Eligible Professionals should note that the Wisconsin Medicaid PI 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.

The standard deduction for Program Year **2021** is 4.47 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 - 0.0447), which is 0.9553, divide that number by their total eligible member patient encounter volume, and then multiply by 100 to convert it to a percentage.

Topic #12078

Patient Volume Requirements and Calculations

In addition to other PI (Promoting Interoperability) 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 PI 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.

Topic #18077

Documentation Requirements

In its Final Rule (42 C.F.R. Part 495), the federal CMS (Centers for Medicare & Medicaid Services) published guidance on collecting supporting documentation prior to an incentive payment being paid. This supporting documentation is used to validate information provided for the incentive payment and to ensure program integrity.

As a result of CMS's guidance, Eligible Professionals are required to submit a copy of the reports used to enter eligible member patient volume for their Wisconsin Medicaid PI (Promoting Interoperability) Program application in order to support their patient volume attestation. The report submission method varies depending on whether an Eligible Professional is reporting individual patient volume or group practice patient volume.

Note: The new documentation requirements do not affect how Eligible Professionals calculate individual or group practice patient volume.

Eligible Professionals Reporting Individual Patient Volume

Eligible Professionals reporting individual patient volume are required to submit a copy of the detail report used to enter patient volume for their Wisconsin Medicaid PI Program application for their selected 90-day volume reporting period. The detail report must include the following information:

- NPI (National Provider Identifier)
- The following details regarding each reported patient encounter (a patient encounter is defined as any services rendered on any one day):

- DOS (date of service)
- Unique patient identifier. The identifier must be either a Medicaid ID or patient name if the encounter is counted as a Medicaid encounter. Alternative patient identifiers may be used for all non-Medicaid encounters (for example, Medical Record Number or Patient Control Number)
- Financial payer (for example, Medicaid fee-for-service, managed care, commercial health insurer, Medicare) or an indication that the encounter is considered a Medicaid encounter
- Out-of-state Medicaid encounters (for example, name of the State Medicaid Agency), if applicable
- Indication that the encounter is considered an "other needy" encounter (for example, provided at no cost or on a sliding fee scale), only applicable if needy individual patient volume is reported

Note: Patient encounter details should support both the patient volume numerator (before the standard deduction, if applicable) and denominator entered in the Wisconsin Medicaid PI Program application.

Eligible Professionals Reporting Group Practice Patient Volume

Eligible Professionals attesting to group practice patient volume are required to submit the following:

- Summary report of the provider information included in the group practice patient volume calculation
- Detail report (used to enter patient volume) that supports the information provided in the summary report

Organizations (at the group NPI level) using the group patient volume calculation for more than one Eligible Professional's Wisconsin Medicaid PI Program application will be required to submit the same summary report and detail report for each application. This means summary and detail reports provided for each Eligible Professional application should not vary from one application to another for the same organization and will not require any additional data manipulation.

Eligible Professionals reporting group practice patient volume will be required to submit the group practice's summary report used to enter patient volume for their Wisconsin Medicaid PI Program application for their selected 90-day volume reporting period. The summary report must include the following information for each provider included in the group practice patient volume calculation:

- Provider name
- NPI
- Individual Medicaid encounter volume (numerator) and total encounter volume (denominator) totals for each provider included in the group practice patient volume calculation

In addition, Eligible Professionals reporting group practice patient volume are required to submit a copy of the group practice's detail report used to enter patient volume for their Wisconsin Medicaid PI Program application for their selected 90-day volume reporting period. The detail report must include the following information:

- Group and provider NPIs
- The following details regarding each reported patient encounter (a patient encounter is defined as any services rendered on any one day):
  - DOS
  - Unique patient identifier. The identifier must be either a Medicaid ID or patient name if the encounter is counted as a Medicaid encounter. Alternative patient identifiers may be used for all non-Medicaid encounters (for example, Medical Record Number or Patient Control Number)
  - Financial payer (for example, Medicaid fee-for-service, managed care, commercial health insurer, Medicare) or an indication that the encounter is considered a Medicaid encounter
  - Out-of-state Medicaid encounters (for example, name of the State Medicaid Agency), if applicable
  - Indication that the encounter is considered an "other needy" encounter (for example, provided at no cost or on a sliding fee scale), only applicable if needy individual patient volume is reported

Note: Patient encounter details should support both the patient volume numerator (before the standard deduction, if applicable)

and the denominator entered in the Wisconsin Medicaid PI Program application.

Alternative supporting documentation may be submitted for Eligible Professionals who do not have claims with their current group practice during the 90-day patient volume reporting period to support they are either new to practicing medicine (for example, a recent graduate of an appropriate training program) or reporting at least one patient encounter from a previous practice.

Submission Requirements

Eligible Professionals attesting on their own behalf using individual patient volume are required to upload their supporting documentation to the Wisconsin Medicaid PI Program application. Organizations attesting on behalf of more than one Eligible Professional using individual patient volume may upload supporting documentation to each application or may submit the patient volume documentation for all Eligible Professionals via one secure email.

Uploading Documentation

Eligible Professionals who are uploading supporting documentation are required to upload it through the Application Submission (Part 1 of 2) page in the Submit section of the Wisconsin Medicaid PI Program application. Eligible Professionals are strongly encouraged to use a Microsoft Excel spreadsheet(s) for their patient volume report(s). For specific instructions on uploading required supporting documentation, Eligible Professionals should refer to the Wisconsin Medicaid Promoting Interoperability Program User Guide for Eligible Professionals on the User Guides page of the ForwardHealth Portal.

Emailing Documentation

If submitting supporting documentation via email, Eligible Professionals are required to do the following:

- To ensure documentation is applied to the appropriate application, the individual patient volume detail report should be named, "Patient Volume_Eligible Professional NPI".
- Encrypt all confidential information.
- Attach the detail report(s) to the email.
- Indicate the following as the subject line of the email: "Eligible Professional Application Supporting Documentation."
- Attach the rest of the required documentation to the email before sending it to the Wisconsin Medicaid PI Program at DHSPromotingInteroperabilityProgram@dhs.wisconsin.gov.

Eligible Professionals are encouraged to send their CEHRT, (Certified Electronic Health Record Technology) patient volume, and Meaningful Use measure documentation in a single email.

Registration and Applying

Topic #12057

Individuals Applying for the Promoting Interoperability Program

A secure Provider account on the ForwardHealth Portal is required to apply for the Wisconsin Medicaid PI (Promoting Interoperability) 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 PI Program:

- The Eligible Professional needs to first log in to the Portal. If the Eligible Professional does not have a Portal account, they need to obtain one. The Eligible Professional should refer to the Account User Guide on the User Guides page of the Portal for more information on obtaining a Portal account.
- The Eligible Professional needs to click on the Wisconsin Medicaid PI 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 Promoting Interoperability Program on Behalf of Eligible Professionals

A secure Provider Portal account is required to apply for the Wisconsin Medicaid PI (Promoting Interoperability) 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 PI 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 User Guides page of the Portal for more information on obtaining a Portal account.
- Portal Administrators will automatically have access to the Wisconsin Medicaid PI Program application. Organizations may assign the new "EHR Incentive" role to a clerk to conduct all Wisconsin Medicaid PI Program business.
- The organization may access the PI Program application by clicking on the Wisconsin Medicaid PI 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 Promoting Interoperability Program with CMS

All Eligible Professionals are required to first register at the R&A (Medicare and Medicaid Electonic Health Record Incentive Program Registration and Attestation System) website. 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, the federal CMS (Centers for Medicare and Medicaid Services) will process the registration and send the file to the Wisconsin Medicaid PI (Promoting Interoperability) Program. After receipt of the file, the Wisconsin Medicaid PI 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 PI Program to allow for this process.

Topic #12058

Required Information When Starting the Promoting Interoperability Program Application

Eligible Professionals will be required to supply specific information when completing the PI (Promoting Interoperability) 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 email 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 PI 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 federal 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 PI Program Application

After completing attestations for the PI (Promoting Interoperability) 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 their name and relationship to the Eligible Professional and then electronically sign the application before submission. Once the Wisconsin Medicaid PI Program application has been completed and submitted, an email 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.

Eligibility

Topic #12038

Eligible Professionals for Promoting Interoperability Program

To be eligible to participate in the Wisconsin Medicaid PI (Promoting Interoperability) 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 PI 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

Meaningful Use of Certified EHR Technology

Topic #13357

Definition of Meaningful Use

The Medicare and Medicaid PI (Promoting Interoperability) Programs provide a financial incentive for the Meaningful Use of certified technology to achieve health and efficiency goals. By implementing and using EHR (electronic health record) 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.

Eligible Professionals are required to attest to cooperation with the following policies:

- Demonstration of supporting information exchange and prevention of information blocking
- Demonstration of good faith with a request relating to the Office of the National Coordinator for Health Information Technology direct review of CEHRT

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 PI (Promoting Interoperability) Program.

In Program Year 2020, the EHR reporting period for all Eligible Professionals is any continuous 90 days between January 1, 2020, and December 31, 2020.

In Program Year 2021, the EHR reporting period for all Eligible Professionals is any continuous 90 days between January 1, 2021, and July 31, 2021.

Topic #13377

Meaningful Use Criteria Overview

CMS (Centers for Medicare & Medicaid Services) has split the Meaningful Use criteria into separate stages that have been

introduced over the course of the PI (Promoting Interoperability) Program through the federal rulemaking process.

- Stage 1 sets the baseline for electronic data capture and information sharing.
- Stage 2 and Modified Stage 2 advance clinical practices and further promote information sharing.
  - CMS established a modified set of criteria for attestation in Program Years 2015 through 2018, known as Modified Stage 2. Modified Stage 2 replaces the core and menu structure of Stages 1 and 2 with a single set of objectives and measures, and establishes several other changes to the PI Program.
  - Eligible Professionals will no longer attest to Stage 1 and Stage 2 criteria. Archived versions of the Online Handbook containing previous attestation criteria are available for audit purposes.
- Stage 3 uses advanced clinical practices to improve outcomes.

Requirements for Stage 3 Meaningful Use

The requirements for Stage 3 contain eight objectives with one or more measures to which Eligible Professionals are required to attest. Eligible Professionals will attest to all eight objectives by either meeting the measure or satisfying an exclusion, if applicable. Eligible Professionals may choose to satisfy an exclusion, rather than meet the measure, when the measure is not applicable to them and they meet the exclusion criteria.

Information for Eligible Professionals regarding objectives and measure specifications is available in the CMS (Centers for Medicare and Medicaid Services) Stage 3 Meaningful Use Specification Sheets.

Stage 3 includes flexibility within certain objectives to allow Eligible Professionals to choose the measures most relevant to their patient population or practice. The Stage 3 objectives with flexible measure options include:

- Coordination of Care through Patient Engagement—Eligible Professionals must attest to all three measures and must meet the thresholds for two measures for this objective. If the Eligible Professional meets the criteria for exclusion from one measure, the remaining two measure thresholds must be met. If the Eligible Professional meets the exclusion criteria for two measures, the threshold for the one remaining measure must be met. If the Eligible Professional meets the exclusion criteria for all three measures, they may claim all three exclusions and satisfy the objective.
- Health Information Exchange—Eligible Professionals must attest to all three measures and must meet the thresholds for two measures for this objective. If the Eligible Professional meets the criteria for exclusion from one measure, the remaining two measure thresholds must be met. If the Eligible Professional meets the exclusion criteria for two measures, the threshold for the one remaining measure must be met. If the Eligible Professional meets the exclusion criteria for all three measures, they may claim all three exclusions and satisfy the objective.
- Public Health Reporting—Eligible Professionals must meet two measures for this objective. If the Eligible Professional cannot satisfy at least two measures, they may claim exclusions from all remaining measures they cannot meet to satisfy this objective.

Stage 3 Objective 1, Protect Electronic Health Information

For Program Year 2020, the SRA (Security Risk Analysis) must be completed prior to the date of attestation and no later than December 31, 2020. For groups, practices may provide one SRA for all of their Eligible Professionals.

For Program Year 2021, Eligible Professionals do not need to complete the SRA prior to the date of attestation, but it must be completed by the end of day on December 31, 2021. Eligible Professionals who do not have the SRA completed by the date of attestation must attest to their intent to complete it by December 31, 2021.

Stage 3 Public Health Reporting Objective

For Stage 3, Eligible Professionals are required to attest to a consolidated public health objective, which has five measure options.

Public Health and Clinical Data Registry Reporting Objective and Measures

The public health and clinical data registry reporting objective requires Eligible Professionals to demonstrate active engagement with a public health agency or clinical data registry to submit electronic health data from CEHRT (Certified Electronic Health Record Technology). The public health and clinical data registry reporting objective contains five measure options. In Program Years 2020 and 2021, all Eligible Professionals must do one of the following:

- Meet two or more of the five measure options
- Meet fewer than two measures and satisfy the exclusion criteria for all other measure options
- Satisfy the exclusion criteria for all measure options

Note: If an Eligible Professional is in active engagement with two public health or clinical data registries, they may choose to report on these measures twice to meet the required number of measures for the public health reporting objective.

The following is an overview of the public health and clinical data registry reporting objective for Eligible Professionals with details on how to successfully demonstrate active engagement and obtain supporting documentation for public health reporting.

The following table shows the five measure options that make up the public health and clinical data registry reporting objective.

Measure Number and Name	Measure Specification	Maximum Times Measure Can Count	Exclusion Criteria
Measure 1—Immunization Registry Reporting	The Eligible Professional is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system.	1	If any of the following apply: - Does not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR (electronic health record) reporting period. - Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific Meaningful Use standards at the start of the EHR reporting period. - Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data as of six months prior to the start of the EHR reporting period.
	The Eligible Professional is in active engagement with a public health agency to submit syndromic surveillance data.	1	If any of the following apply: - Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system. - Operates in a jurisdiction for which no public

Measure 2—Syndromic Surveillance Reporting			health agency is capable of receiving electronic syndromic surveillance data from Eligible Professionals in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period. - Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from Eligible Professionals as of six months prior to the start of the EHR reporting period.
Measure 3—Electronic Case Reporting	The Eligible Professional is in active engagement with a public health agency to submit case reporting of reportable conditions.	1	If any of the following apply: - Does not diagnose or directly treat any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the EHR reporting period. - Operates in a jurisdiction for which no public health agency is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period. - Operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data as of six months prior to the start of the EHR reporting period.
Measure 4—Public Health Registry Reporting	The Eligible Professional is in active engagement with a public health agency to submit case reporting of reportable conditions.	2	If any of the following apply: - Does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the EHR reporting period. - Operates in a jurisdiction for which no public health agency can accept electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period. - Operates in a jurisdiction where no public health agency for which the Eligible Professional is

			eligible to submit data has declared readiness to receive electronic registry transactions as of six months prior to the start of the EHR reporting period.
Measure 5—Clinical Data Registry Reporting	The Eligible Professional is in active engagement to submit data to a clinical data registry.	2	If any of the following apply: - Does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the EHR reporting period. - Operates in a jurisdiction for which no clinical data registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period. - Operates in a jurisdiction where no clinical data registry for which the Eligible Professional is eligible to submit data has declared readiness to receive electronic registry transactions as of six months prior to the start of the EHR reporting period.

Note: In determining whether an Eligible Professional meets the first exclusion for each measure, the registries in question are those sponsored by the public health agencies with jurisdiction over the area where the Eligible Professional practices and by national medical societies covering the Eligible Professional's scope of practice. Therefore, an Eligible Professional is required to complete a minimum of two actions in order to determine available registries or claim an exclusion: 1) determine if the jurisdiction (state, territory, etc.) endorses or sponsors a registry, and 2) determine if a National Specialty Society or other specialty society with which the provider is affiliated endorses or sponsors a registry. Registries sponsored by Wisconsin can be found on the Public Health Meaningful Use website.

Demonstrating Active Engagement for Public Health Reporting

For the Stage 3 public health reporting objective, Eligible Professionals are required to be in active engagement with a public health agency to submit electronic public health data from CEHRT. Active engagement means the Eligible Professional is progressing toward sending production data or is sending production data to a public health agency or clinical data registry. Submitting production data shows that an Eligible Professional regularly reports data generated through clinical processes involving patient care from CEHRT to a public health program using appropriate standards and specifications.

An Eligible Professional can meet a public health reporting measure by registering to submit data and demonstrating any of the following Stage 3 active engagement options:

- Option 1—Completed Registration to Submit Data: The Eligible Professional registered to submit data with the public health agency or, where applicable, with the clinical data registry to which the information is being submitted; registration was completed no later than 60 days after the start of their EHR reporting period; and the Eligible Professional is awaiting invitation to begin testing and validation. With this option:

- Eligible Professionals are able to meet the measure even when the public health agency or clinical data registry has limited resources to initiate the testing and validation process.
- Eligible Professionals are able to meet the measure by registering their intent to report with a registry if a registry declares readiness at any point in the calendar year after the initial 60 days. (However, if an Eligible Professional had already planned to exclude based on the registry not being ready to allow for registrations of intent within the first 60 days of the reporting period, they may still exclude for that calendar year.)
- Eligible Professionals who have completed registration in previous years do not need to submit a new registration to meet this requirement for each EHR reporting period as long as the registration accurately reflects their intent to submit data. Eligible Professionals whose completed registrations do not accurately reflect their intent to submit data for a public health measure are required to update their registration no later than 60 days after the start of their EHR reporting period.

For example, if an Eligible Professional previously only registered intent to submit immunization data and has now decided to also attest to the specialized registry measure for cancer reporting, the Eligible Professional will have to update the existing registration.

- Option 2—Testing and Validation: The Eligible Professional is in the process of testing and validation of the electronic submission of data.
- Option 3—Production: The Eligible Professional has completed testing and validation of the electronic submission and is electronically submitting production data to the public health agency or clinical data registry.

Public Health Reporting Exclusions

There are multiple exclusions for each of the public health reporting measures. Claiming an exclusion for a measure does not count toward the total number of public health reporting measures an Eligible Professional is required to meet. Instead, to meet the public health objective, an Eligible Professional is required to do one of the following:

- Demonstrate active engagement with a public health agency for at least two measures.
- Demonstrate active engagement with a public health agency for less than two measures and claim an applicable exclusion for all remaining measures.

Eligible Professionals who do not collect appropriate or relevant data to submit to a public health agency may be able to claim an exclusion or pick another public health reporting measure. If an Eligible Professional meets the exclusion criteria, they can claim the exclusion to the measure. If an Eligible Professional is part of a group that submits data to a registry, but the Eligible Professional does not contribute to that data (for example, does not administer immunizations), the Eligible Professional should not attest to meeting the measure and should claim the exclusion.

Although exclusions are available for the public health reporting measures, the Wisconsin Medicaid Promoting Interoperability Program does not formally grant exclusions to Eligible Professionals or offer documentation for Eligible Professionals to use when claiming an exclusion. Eligible Professionals are required to self-attest to exclusions in the attestation system based on CMS exclusion criteria. It is the Eligible Professional's responsibility to claim an exclusion and maintain the proper documentation to substantiate the attestation.

Meaningful Use Audit 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 #19218

Registration for Public Health Program

All Eligible Professionals participating in Meaningful Use (regardless of scheduled stage) should register with DPH (Wisconsin

Division of Public Health) for the public health program and/or registry (e.g., immunizations) to which they intend to electronically submit data. In January 2014, DPH launched PHREDS (Public Health Registration for Electronic Data Submission System), a Microsoft® SharePoint® site where Eligible Professionals register their intent to submit data from CEHRT to a public health program/registry. Eligible Professionals who would like to electronically submit data from CEHRT to a public health program are required to register through PHREDS.

After a registration form is successfully submitted in PHREDS, Eligible Professionals receive a registration confirmation email and are put into a queue with the public health registries for which they have registered. Eligible Professionals in the queue will await an invitation from registry personnel to begin the onboarding process. Onboarding is the testing and validation process Eligible Professionals and public health programs engage in prior to the achievement of ongoing submission of production data. Each registry has a separate process for onboarding Eligible Professionals, but all use PHREDS to manage registrations and the onboarding queue.

In order to meet active engagement option one, all Eligible Professionals who collect the appropriate data should register their intent to submit data to the relevant public health registry no later than 60 days after the start of their EHR reporting period. Based on the registry's onboarding policies, Eligible Professionals may not be invited to further participate in the onboarding process before their EHR reporting period ends; however, they will have successfully demonstrated the public health reporting objective criteria for Active Engagement Option 1 — Completed Registration to Submit Data (and would not have to claim an exclusion).

Meaningful Use Acknowledgements for Public Health Programs

Meaningful Use Acknowledgements are the mechanism DPH uses to acknowledge that Eligible Professionals have registered, completed a test, or reached ongoing submission of production data from CEHRT. The Wisconsin Medicaid EHR Incentive Program strongly encourages Eligible Professionals to retain these documents (i.e., registration confirmation email and Acknowledgements file) because they are the only forms of documentation produced by DPH for this purpose.

The Wisconsin Medicaid EHR Incentive Program also recommends that all Eligible Professionals save a copy of the Acknowledgements file (in Excel format) dated after the end of their EHR reporting period, even if they are still in the onboarding queue or have achieved ongoing submission of production data. In the event of an audit, Eligible Professionals will use the Acknowledgments file to substantiate their Meaningful Use attestation. The auditor will want to see an Acknowledgments file dated after the end of the EHR reporting period being audited, to confirm the organization's or site's active engagement status with the public health registry at that time. To facilitate the audit process, all Eligible Professionals are encouraged to save a printed or PDF copy of the PHREDS page explaining the contents of the Acknowledgements file.

Specialized Registries

Modified Stage 2 allows for a wide range of reporting options now and in the future, explicitly stating that Eligible Professionals may choose to report to clinical data registries to satisfy the measure. This means the category of specialized registries used to satisfy the specialized registry measure is not limited to those sponsored by state or local public health agencies, and Eligible Professionals may work with specialized registries outside of DPH to satisfy the Specialized Registry Reporting measure. The registries outside of DPH might include applicable registries sponsored by the Centers for Disease Control and Prevention, national medical specialty organizations, patient safety organizations, and/or quality improvement organizations. This flexibility in use of specialized registries allows Eligible Professionals to continue in the direction they may have already planned for reporting to specialized registries.

The DPH does not provide registration, administrative onboarding, compliance, or audit support to Eligible Professionals trying to meet the Specialized Registry Reporting measure if the an Eligible Professional has chosen to use a registry outside of those offered by DPH. Eligible Professionals are strongly encouraged to consider the availability of supporting documentation before attesting to the use of a specialized registry outside of those offered by DPH. In order to be considered a specialized registry by the Wisconsin Medicaid EHR Incentive Program, the agency/registry must:

- Publicly declare readiness to receive electronic data submissions.
- Publicly declare the ability to support the registration/onboarding and production processes.

- Provide proper documentation to providers to support active engagement.

Documentation maintained by an Eligible Professional to support electronic data submission to the specialized registry may also be used, in addition to any documentation provided by the agency/registry.

Eligible Professionals will be prompted to attest to the name of the specialized registry during the application process. The Wisconsin Medicaid EHR Incentive Program also encourages Eligible Professionals to upload documentation supporting their attestation. If an Eligible Professional is intending to attest to a specialized registry sponsored by DPH, appropriate documentation would be the Acknowledgements file provided on the PHREDS SharePoint site.

Topic #21677

Stage 3 Meaningful Use Supporting Documentation

Documentation Required at Attestation

Eligible Professionals are required to submit the following documentation to support attestation:

- CEHRT (Certified Electronic Health Record Technology) documentation.
- Patient volume documentation.
- SRA (Security Risk Assessment) documentation.
  - For Program Year 2020: The SRA must be submitted with the application. For groups, practices may provide one SRA for all of their Eligible Professionals.
  - For Program Year 2021: If the SRA has been completed by the date of attestation, the Eligible Professional is required to submit the SRA documentation with the application. If the SRA has not been completed by the date of attestation, the Eligible Professional is required to complete it by the end of day December 31, 2021. Upon completion of the SRA, the Eligible Professional must submit the supporting documentation to the DHS (Wisconsin Department of Health Services) via secure email to dhspromotinginteroperabilityprogram@dhs.wisconsin.gov by the end of day, January 31, 2022. The Eligible Professional must identify the organization to which the SRA applies, so it may be properly applied to all applicable Eligible Professionals. Eligible Professionals who do not complete their SRAs by December 31, 2021, and submit their SRA documentation by the January 31, 2022, deadline are subject to audit and may have their incentive recouped.
  - Meaningful Use report(s) supporting all Meaningful Use percentage-based measures (with numerators and denominators) and/or any other source material used by the Eligible Professional to enter the Meaningful Use measure numerators and denominators.

Applicable percentage-based measures include:

Stage 3
- Objective 2: Electronic Prescribing, Measure 1 - Objective 4: Computerized Provider Order Entry, Measures 1-3 - Objective 5: Patient Electronic Access to Health Information, Measures 1 and 2 - Objective 6: Coordination of Care through Patient Engagement, Measures 1-3 - Objective 7: Health Information Exchange, Measures 1-3

Eligible Professionals should use SRA documentation and Meaningful Use reports to demonstrate that requirements were met for Meaningful Use measures during the EHR (electronic health record) reporting period. For percentage-based measures, Eligible Professionals' EHR will electronically record the numerator and denominator and generate a report that includes the numerator,

denominator, and percentage. If their Meaningful Use reports do not support the exact data entered in the Attestation section of the application, Eligible Professionals may also submit any other source material used to enter the Meaningful Use measure numerators and denominators.

Eligible Professionals are not required to submit documentation supporting their Electronic Clinical Quality Measures.

The following table further describes the acceptable types of documentation:

Documentation Type	Documentation Description	Submission Method	Required
Security Risk Analysis	For Objective 1, Protect Patient Health Information, supply detail on security risk analysis including: - 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 Note: No exclusion is available for this objective.	Upload or email*	Yes
Meaningful Use Reports	This type of documentation can be used for: - Percentage-based measures - Any claimed exclusions where the report displays a "0" for the or the report displays a denominator that is less than a threshold specified in the measure exclusion criteria. (For example, if the requirement states that an exclusion may be used by an Eligible Professional with "less than 100 orders" and the report supports that the Eligible Professional had less than 100 orders.) - If Eligible Professionals' Meaningful Use reports do not support the exact data entered in the Attestation section of the application, they may also submit any other source materials used to enter the Meaningful Use measure numerators and denominators.	Upload or email*	Yes

*Send a secure email to dhspromotinginteroperabilityprogram@dhs.wisconsin.gov.

Stage 3 Meaningful Use Audit 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 Promoting Interoperability Incentive Program under Stage 3 Meaningful Use.

	Measure	Required Documentation	Required Exclusion Documentation
General Requirement 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	ı List of total encounters with detail including date, patient identifier, payer, and rendering provider ı List of encounter with CEHRT with detail on location and CEHRT used	N/A
General Requirement 02: Unique Patients in CEHRT	Must have 80 percent or more of their unique patient data in the CEHRT during the EHR reporting period	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)	N/A
Objective 01	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies	ı Documentation of procedures performed during the analysis, results and person(s) who performed the assessment ı Evidence that the deficiencies noted during the assessment were recorded ı A remediation plan developed based on the risks identified by the assessment ı Verification that encryption and security of data stored in the EHR technology has been addressed ı Verification that the assessment was completed prior to the date of attestation Required Elements: IT Asset Inventory & Final Report	N/A
	More than 60 percent of all permissible prescriptions written by the Eligible Professional are	ı CEHRT generated report showing numerator and denominator and ı Verification each Rx was queried	Evidence Eligible Professional wrote fewer than 100 permissible prescriptions, or no pharmacy

Objective 02	queried for a drug formulary and transmitted electronically using CERHT	for a drug formulary (CEHRT Screenshots showing Formulary)	within your organization and no pharmacies that accept electronic prescriptions within 10 miles of the Eligible Professional's practice location
Objective 03 Measure 01	Implement five clinical decision support interventions related to four or more clinical quality measures	Screen shot(s) demonstrating implementation of the rules and alignment with four clinical quality measures as well as a list of the five clinical support rules implemented	N/A
Objective 03 Measure 02	Implement drug-drug and drug-allergy checks	Screenshot(s) and/or an audit log from the CEHRT showing the system setting for drug-drug and drug-allergy interaction check are enabled	Evidence that the Eligible Professional wrote fewer than 100 medication orders
Objective 04 Measure 01	More than 60 percent of medication orders are recorded using CPOE	- CEHRT generated report showing numerator and denominator for medication orders and - List of individuals who entered CPOE with their credentials or verification CPOE entered by only credentialed individuals	Evidence that the Eligible Professional wrote fewer than 100 medication orders
Objective 04 Measure 02	More than 60 percent of laboratory orders are recorded using CPOE	CEHRT generated report showing numerator and denominator for laboratory orders	Evidence that the Eligible Professional wrote fewer than 100 laboratory orders
Objective 04 Measure 03	More than 60 percent of diagnostic imaging orders are recorded using CPOE	CEHRT generated report showing numerator and denominator for diagnostic imaging orders	Evidence that the Eligible Professional wrote fewer than 100 diagnostic imaging orders
	More than 80 percent of all unique patients are provided timely online access to view, download, and transmit their health information and provider ensures patient's health information is available for the patient to access using any application of their choice that meets Application Programming Interface in the CEHRT	- CEHRT generated report showing numerator and denominator and - Evidence the Eligible Professional has installed and is using a Patient Portal or an ePHR solution (screenshots showing patient portal and documentation explaining how patients are directed to the portal) and - Evidence provider has made patient's health information	Evidence the Eligible Professional had no office visits during the EHR reporting period

Objective 05 Measure 01		available using any application that meets CEHRT Application Programming Interface requirements (date Application Programming Interface was enabled, screenshots verifying Application Programming Interface functionality and documentation explaining how patients are informed of availability of the Application Programming Interface functionality)	
Objective 05 Measure 02	More than 35 percent of all unique patients specific educational resources along with electronic access to the educational materials identified by CEHRT	- CEHRT generated report showing numerator and denominator and - Documentation confirming use of patient education materials is based on information stored in the CEHRT system (screen shots showing patient educational materials are available electronically in the CEHRT or EHR-generated reports)	Evidence the Eligible Professional had no office visits
Objective 06 Measure 01	More than five percent of all unique patients actively engage with the EHR and view, download or transmit their health information or access their information through the use of an Application Programming Interface	CEHRT generated report showing numerator and denominator	Evidence that the Eligible Professional did not have any office visits
Objective 06 Measure 02	More than five percent of all unique patients sent or received a secure electronic message using the electronic messaging function of the CEHRT	CEHRT generated report showing numerator and denominator	Evidence that the Eligible Professional did not have any office visits
	More than five percent of all unique patients have patient	CEHRT generated report showing numerator and denominator	Evidence that the Eligible Professional did not have any

Objective 06 Measure 03	generated health data or data from a non-clinical setting incorporated into the CEHRT		office visits
Objective 07 Measure 01	More than 50 percent of transitions of care and referrals (outgoing) had a summary of care record created by the CEHRT and electronically exchanged the summary of care record with the receiving party	ı CEHRT generated report showing numerator and denominator and ı Summary of care record sample and ı Explanation of how the summary of care records were transmitted or log of exchange that took place during the EHR reporting period	Evidence that the Eligible Professional transferred or referred patients to another setting or provider less than 100 times
Objective 07 Measure 02	More than 40 percent of transitions of care and referrals received (incoming) by the provider had a summary of care record incorporated into the CEHRT by the provider	ı CEHRT generated report showing numerator and denominator and ı Documentation confirming a summary of care document from another provider was incorporated into the provider's CEHRT	Evidence that the total transitions or referrals received and patient encounters in which the provider has never encountered the patient is fewer than 100
Objective 07 Measure 03	More than 80 percent of transitions of care and referrals received (incoming) by the provider had a clinical information reconciliation performed, including: medications, medication allergies and problem lists (a review of patients current and active diagnoses)	CEHRT generated report showing numerator and denominator	Evidence that the total transitions or referrals received and patient encounters in which the provider has never encountered the patient is fewer than 100
Objective 08 Measure 01	Note: Eligible Professional must attest to two of the five measures Eligible Professional is in active engagement with a public health agency to submit immunization data and receive immunization forecast	Confirmation the provider has registered with the DHS PHREDS (Public Health Registration for Electronic Data Submission System) program and documentation verifying ongoing submission (or intent of ongoing submission) and documentation verifying the provider is receiving immunization forecasts	Evidence that the Eligible Professional did not perform immunizations
	Eligible Professional is in active engagement with a public health	Confirmation the provider has registered with the DHS PHREDS program and	Documentation verifying the provider is not in a category of

Objective 08 Measure 02	agency to submit syndromic surveillance data	documentation verifying ongoing submission (or intent of ongoing submission)	providers from which ambulatory syndromic surveillance data is collected
Objective 08 Measure 03	Eligible Professional is in active engagement with a public health agency to submit case reporting of reportable conditions	Confirmation the provider has registered with the DHS PHREDS program and documentation verifying ongoing submission (or intent of ongoing submission)	Documentation verifying the provider does not treat or diagnose any reportable diseases for which data is collected by their jurisdictions reportable disease system
Objective 08 Measure 04	Eligible Professional is in active engagement with a public health agency to submit data to public health agencies	Confirmation the provider has registered with the DHS PHREDS program and documentation verifying ongoing submission (or intent of ongoing submission)	Documentation verifying the provider does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction (Verification statement that the provider conducted a due diligence search and was unable to locate a specialized registry in their jurisdiction that they potentially could submit data to)
Objective 08 Measure 05	Eligible Professional is in active engagement with a public health agency to submit data to a clinical data registry	Documentation verifying the provider is in active engagement with a clinical data registry	Documentation verifying the provider does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction (Verification statement that the provider conducted a due diligence search and was unable to locate a specialized registry in their jurisdiction that they potentially could submit data to)

Clinical Quality Measures

Topic #16879

Electronic Clinical Quality Measures Overview

The eCQMs (Electronic 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 eCQMs are reported separately from Meaningful Use measures, all Eligible Professionals are still required to report eCQMs in order to demonstrate Meaningful Use successfully.

Per CMS (Centers for Medicare & Medicaid Services), Eligible Professionals must report on a total of six clinical quality measures. Of the six, one must be an "outcome" measure. If no outcome measures are relevant to the provider's scope of practice, then the provider must report on one "high-priority" eCQM. If no outcome or high-priority eCQMs are relevant to the Eligible Professional's scope of practice, the Eligible Professional must report on any six eCQMs. This requirement was new starting in Program Year 2019.

Outcome measures are those that speak to an actual clinical patient outcome rather than measuring whether a process was completed. eCQMs may be designated as high-priority by both CMS and Wisconsin. Eligible Professionals should refer to the Wisconsin DHS (Department of Health Services) eHealth Program Quality Series: "Wisconsin High-Priority Electronic Clinical Quality Measures" for more information on this requirement and the list of outcome and high-priority eCQMs designated by CMS or Wisconsin or both.

Additionally, CMS selected all eCQMs 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:

- Person and caregiver-centered experience and outcomes
- Patient safety
- Communication and care coordination
- Community/population health
- Efficiency and cost reduction
- Effective clinical care

Zero is an acceptable value for the eCQM denominator, numerator, and exclusion fields and will not prevent an Eligible Professional from demonstrating Meaningful Use or receiving an incentive payment. Eligible Professionals can meet the eCQM requirements even if one or more eCQM has "0" in the denominator, provided that this value was produced by CEHRT (certified electronic health record technology).

See the CMS Clinical Quality Measure Basics page of the CMS website to learn more about reporting eCQMs. For a complete listing of eCQMs, refer to the eCQM Library page of the CMS website.

Electronic Clinical Quality Measure Reporting Period

The following date ranges are the eCQM reporting periods for the Meaningful User for Program Years 2020 and 2021:

- Program Year 2020: The eCQM reporting period for Eligible Professionals is any continuous 90-day period between January 1, 2020, and December 31, 2020.
- Program Year 2021: The eCQM reporting period for Eligible Professionals is any continuous 90-day period between January 1, 2021, and July 31, 2021.

Topic #16880

Wisconsin Medicaid-Recommended Clinical Quality Measures

Eligible Professionals report CQMs (clinical quality measures) through attestation at an aggregate level. 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: LDL (Low Density Lipoprotein) Management	Clinical Process/Effectiveness	A	
CMS164v1	0068	IVD: Use of Aspirin or Another Antithrombotic	Clinical Process/Effectiveness	A	
CMS154v1	0069	Appropriate Treatment for Children with URI (Upper Respiratory Infection)	Efficient Use of Healthcare Resources	A	Pediatric Recommended Core Measure
CMS161v1	0104	MDD (Major Depressive Disorder): Suicide Risk Assessment	Clinical Process/Effectiveness	B	
CMS128v1	0105	Anti-depressant Medication Management	Clinical Process/Effectiveness	A	
CMS136v2	0108	ADHD (Attention-Deficit/Hyperactivity Disorder): Follow-Up Care for Children Prescribed ADHD Medication	Clinical Process/Effectiveness	A	Pediatric Recommended Core Measure
CMS62v1	0403	HIV/AIDS: Medical Visit	Clinical Process/Effectiveness	A	
CMS52v1	0405	HIV/AIDS: PCP (Pneumocystis Jiroveci Pneumonia) 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	Population/Public Health	A	Adult Recommended Core Measure Pediatric

		Follow-Up Plan			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: BMI (Body Mass Index) Screening and Follow-Up	Population/Public Health	B	Adult Recommended Core Measure
CMS159v1	0710	Depression Remission at 12 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