

Claims

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Archive Date:10/01/2026

Claims:Overpayments

Topic #8417

Voiding Claims

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

Responses

Topic #535

Claim Status

ForwardHealth generally processes claims and adjustment requests within 30 days of receipt. Providers may check the status of a claim or adjustment request using the [AVR \(Automated Voice Response\)](#) system or the 276/277 (276/277 Health Care Claim Status Request and Response) transaction.

If a claim or adjustment request does not appear in claim status within 45 days of the date of submission, a copy of the original claim or adjustment request should be resubmitted through normal processing channels.

ForwardHealth claims generally fall into one of three statuses:

- ▮ Pay—The claim has been approved for payment.
- ▮ Deny—The claim was not approved for payment.
- ▮ Suspend—The claim is awaiting further review by ForwardHealth before a decision is made on how the claim will be adjudicated.

Refer to the ForwardHealth Portal Claim Status Information Instruction Sheet on the [User Guides](#) page of the Portal for additional information regarding claim status.

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 \(02/2025\)\)](#) 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 #516

Accuracy of Claims

The provider is responsible for the accuracy and completeness of all claims submitted either by the provider or by an outside billing service or clearinghouse.

ForwardHealth requires that all codes indicated on claims and PA (prior authorization) requests be valid, including:

- ┆ Diagnosis codes
- ┆ Revenue codes
- ┆ HCPCS (Healthcare Common Procedure Coding System) codes
- ┆ HIPPS (Health Insurance Prospective Payment System) codes
- ┆ CPT (Current Procedural Terminology) codes

Providers should refer to current national coding and billing manuals for information on valid code sets. ForwardHealth will:

- ┆ Deny claims received without valid diagnosis codes, revenue codes, and HCPCS, HIPPS, or CPT codes.
- ┆ For pharmacy providers, return PA requests received without valid codes to the provider.

Providers may submit claims only **after** the service is provided.

A provider may not seek reimbursement from ForwardHealth or a state-contracted HMO for a [noncovered service](#) by charging ForwardHealth for a [covered service](#) that was not actually provided to the member and then applying the reimbursement toward the noncovered service. In addition, a provider may not seek reimbursement for two separate covered services to receive additional reimbursement over the maximum allowed amount for the one service that was provided. Such actions are considered fraudulent.

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.	75% of a provider's reviewed claims over a three-month period must be paid as submitted. The number of	The provider must meet parameters set during the sanction process.

	All providers who bill the service codes that are part of this criteria are subject to review, regardless of their compliance rates.	claims submitted during the three-month period may not drop more than 10% of the provider's volume of submitted claims prior to pre-payment review.	
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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% 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% 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.

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

PA is not required for these advanced imaging services:

- ▮ Services provided during a member's inpatient hospital stay.
- ▮ Services provided when a member is in observation status at a hospital.
- ▮ Services provided as part of an emergency room visit.
- ▮ Services provided as an emergency service.
- ▮ Advanced breast imaging services that meet [certain clinical criteria](#).

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 (Advanced imaging service is exempt from PA requirements) 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.

Advanced Breast Imaging Services Under Certain Circumstances

For the first advanced breast imaging service within a 12-month period, providers must submit claims to ForwardHealth using these CPT (Current Procedural Terminology) procedure codes with modifier UA.

Procedure Code	Description
77046	Magnetic resonance imaging, breast, without contrast material; unilateral
77047	Magnetic resonance imaging, breast, without contrast material; bilateral
77048	Magnetic resonance imaging, breast, without and with contrast material(s); including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis) when performed; unilateral
77049	Magnetic resonance imaging, breast, without and with contrast material(s); including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis) when performed; bilateral
77061	Diagnostic digital breast tomosynthesis; unilateral
77062	Diagnostic digital breast tomosynthesis; bilateral

Topic #21959

Claim Submission Requirements for Encounters

For the purposes of this Online Handbook topic:

- ▮ A [PPS \(prospective payment system\)](#) rate applies to CHCs (community health centers) and Tribal FQHCs (federally qualified health centers).
- ▮ An [AIR \(all-inclusive rate\)](#) applies to Tribal FQHCs only.

CHCs and Tribal FQHCs identify encounters on claims by using HCPCS (Healthcare Common Procedure Coding System) procedure code T1015 (Clinic visit/encounter, all-inclusive) for services rendered. ForwardHealth assigns the appropriate encounter type to the claim detail associated with procedure code T1015 based on the provider type of the rendering provider.

When CHCs and Tribal FQHCs submit claims to ForwardHealth for [encounters](#), they must:

- ▮ Submit claims on either a dental or professional claim form or the electronic equivalent (for example, ADA (American Dental Association) 2012 Claim Form, 1500 Health Insurance Claim Form, 837 Health Care Claim: Dental or Professional transaction), as applicable.
- ▮ Submit each encounter using HCPCS code T1015 in the first detail line. If a single claim is used to bill multiple encounter types (for example, a medical encounter and a dental encounter), the claim should include a separate detail with procedure code T1015 for each encounter per DOS (date of service).
- ▮ Enter procedure code T1015 on only one DOS for the detail(s) associated with one encounter type. Note: Submitting one claim detail for services given over multiple consecutive days is not allowed and will result in a denied claim. The exception is for dentures when the upper and lower dentures are delivered to the member on the same DOS.
- ▮ Understand that the billed amount for HCPCS code T1015 is not required to be the assigned PPS or AIR for each CHC or Tribal FQHC. CHC and Tribal FQHC providers may bill procedure code T1015 for any amount that they deem appropriate, including zero. The reimbursed amount for procedure code T1015 will be the CHC's or Tribal FQHC's assigned PPS rate or AIR.
- ▮ Understand that procedure code T1015 will be allowable for one DOS per the detail(s) associated with one encounter type (span billing is not allowed).
- ▮ List the diagnosis most applicable to the encounter type must be associated with procedure code T1015.
- ▮ Include separate details for all direct and indirect services rendered as part of the encounter in addition to billing procedure code T1015 for each encounter type. CHCs and Tribal FQHCs should use the most appropriate procedure codes to represent [direct and indirect services](#). Each detail should identify the provider who delivered the direct or indirect service as the rendering provider. These services should be billed with the applicable charges.
- ▮ Include at least one allowable direct service associated with the encounter with the same rendering provider as procedure code T1015. Claims not meeting these requirements will not have a PPS rate or AIR applied. Note: Indirect services alone, without an accompanying allowable direct service, are not encounters. Claims for such instances may not include procedure code T1015. The claim will be denied if procedure code T1015 is present with indirect services only and all payable indirect services will process in a paid status with a \$0 allowed amount.
- ▮ List the provider who delivered the services during the encounter as the rendering provider for procedure code T1015. If multiple providers rendered services during a single encounter, the CHC or Tribal FQHC should use its judgment based on its reporting capabilities to identify which provider is the most appropriate to list as the rendering provider for procedure code T1015.
- ▮ Submit claims for services under the NPI (National Provider Identifier) of the CHC or Tribal FQHC based on the physical site where the service was provided. The appropriate billing provider will be determined by the location of the service.
 - ▮ Use the NPI of the CHC or Tribal FQHC main site as the billing provider for **services provided at the main service location**.
 - ▮ Use the NPI of the CHC or Tribal FQHC off-site clinic as the billing provider for **services provided at an off-site clinic**.
 - ▮ Use the NPI of the CHC or Tribal FQHC main site as the billing provider for **services provided at a location other than the CHC's or Tribal FQHC's the main service location or off-site clinic** (for example, at a primary site of an identified contracted clinician).
 - ▮ Use the NPI of the separate pharmacy as the billing provider for **services provided at a CHC or Tribal FQHC pharmacy**.

Federally Qualified Health Center Responsibilities

CHCs and Tribal FQHCs are responsible for ensuring that an encounter is only counted once across all providers involved in that encounter. ForwardHealth pays up to one procedure code T1015 encounter for **each** encounter type (dental, medical, or mental health) per member, per day.

For a single DOS, CHCs and Tribal FQHCs could bill up to three instances of HCPCS code T1015—one for each encounter type. Encounters are assigned an encounter type based on the rendering provider.

Providers may not delay or split services across multiple DOS to bill additional encounters. These actions could result in an OIG (Office of the Inspector General) audit and/or investigation, which could lead to DSPS (Department of Safety and Professional Services) and DOJ (Department of Justice) referrals.

Contracted Provider or Facility

When a member receives services, the contracted provider who performs the service should be listed as the rendering provider on the claim. The billing provider (the CHC or Tribal FQHC) will submit the claim.

Subsequent Encounters

A subsequent encounter is a unique situation that is unplanned or not anticipated. For example, a member sees their provider in the morning for a medical condition and later that same day has a fall and returns to the CHC or Tribal FQHC. Subsequent encounters can be medical, dental, or mental health when the encounter satisfies the subsequent encounter requirements.

Typically, claims are denied if they indicate more than one encounter for a given encounter type for the same member, same CHC or Tribal FQHC organization, and same DOS. However, when the additional encounter represents a subsequent encounter, providers may resubmit the claim with these documents to ForwardHealth for review:

- ┆ The applicable medical documentation supporting the subsequent encounter
- ┆ The Written Correspondence Inquiry form by mail

On the Written Correspondence Inquiry form, providers should check the "Other" box in the Reason for Inquiry field and indicate "Request for review of medical necessity for subsequent encounter" in the space provided. Providers should follow the instructions on the form for submitting the claim, clinical documentation, and form to ForwardHealth. Providers should keep a copy of the claim, clinical documentation, and form for their records.

Telehealth Services

CHCs and Tribal FQHCs may be both [originating site and distant site providers for telehealth services](#).

CHCs and Tribal FQHCs may only submit claims for [qualified telehealth services](#). Procedure codes for services allowed under permanent telehealth policy have POS (place of service) codes 02 (Telehealth Provided Other than in Patient's Home) and 10 (Telehealth Provided in Patient's Home) listed as an allowable POS in the [fee schedules](#).

ForwardHealth assigns a PPS rate for an allowable encounter when CHCs and Tribal FQHCs bill HCPCS code T1015 with a telehealth procedure code.

ForwardHealth includes services billed with these modifiers in PPS reimbursement:

- ┆ FQ (The service was furnished using audio-only communication technology)
- ┆ GT (Via interactive audio and video telecommunication systems)
- ┆ 93 (Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System)

CHCs and Tribal FQHCs should submit claims for originating site services on a professional claim form with HCPCS procedure code Q3014 (Telehealth originating site facility fee) **and** a POS code that indicates where the member received the service.

Providers will not be reimbursed for originating site services under PPS or AIR methods if they use the modifier GT with procedure code Q3014.

ForwardHealth does not separately reimburse the CHC or Tribal FQHC for originating site services because costs of providing originating site services are incorporated into the CHC's or Tribal FQHC's PPS rate or AIR. However, CHC and Tribal FQHC claims for originating site services may be used for future PPS rate-setting purposes, and CHC and Tribal FQHC costs associated with telehealth services may be reported for changes in scope adjustment consideration.

Teledentistry

On a claim form, dental providers must:

- ▮ Identify if the [teledentistry](#) encounter was either:
 - ▮ Synchronous with procedure code D9995 (Teledentistry synchronous; real-time encounter)
 - ▮ Asynchronous with procedure code D9996 (Teledentistry asynchronous; information stored and forwarded to dentist for subsequent review)
- ▮ Include the applicable evaluation procedure codes.

Obstetric Care

ForwardHealth offers providers two choices of how and when to file claims for [obstetric care](#):

- ▮ CHCs and Tribal FQHCs will be reimbursed an encounter for each component for separate obstetric components that are billed as they are performed.
- ▮ CHCs and Tribal FQHCs will be reimbursed for only one encounter for an appropriate global obstetric procedure code with the date of delivery as the DOS.

Carved-Out Services

Carved out services (physician-administered drugs and telehealth distant site services) may be submitted on the same claim as the encounter. Carved-out services procedure codes will be reimbursed using fee-for-service reimbursement.

For example, if a member receives mental health and substance abuse services and also receives an injectable medication with a procedure code found on the [physician-administered drugs crosswalk](#), then the CHC or Tribal FQHC may submit the encounter with the mental health and substance abuse service procedure code to receive the PPS rate **and** the physician-administered drug code to receive the fee-for-service rate.

Some CHCs and Tribal FQHCs provide pharmacy services and bill for them on a ForwardHealth compound or noncompound drug claim. A CHC or Tribal FQHC pharmacy provider must [enroll as a separate Medicaid provider](#) under the applicable pharmacy provider type and specialty. The pharmacy must have the same tax ID as the main service location of the associated CHC or Tribal FQHC.

Medicare Crossover Claims

A Medicare-crossover claim is a Medicare-allowed claim for a dual eligible or Qualified Medicare Beneficiary-Only member sent to ForwardHealth for payment of coinsurance, copay, and deductible corresponding with the fee schedule.

PPS and AIR reimbursement are carved out of (not included in) Medicare Crossover coverage. For Medicare Crossover claims, the total reimbursement for a Medicare Part B-covered service may not exceed the Medicare-allowed amount. This includes any amount paid by other health insurance sources, any copay or spenddown amounts paid by the member, and any amount paid by

Wisconsin Medicaid.

Therefore, Medicaid reimbursement for coinsurance or copay of a Medicare Part B-covered service is the lesser of:

- ▮ The **Medicare**-allowed amount less any amount paid by other health insurance sources and any copay or spenddown amounts paid by the member.
- ▮ The **Medicaid**-allowed amount less any amount paid by other health insurance sources and any copay or spenddown amounts paid by the member.

If a service is not allowable by Medicare or a claim is denied by Medicare, then PPS and AIR could be used. When submitting these claims, the billing provider must include the appropriate [Medicare disclaimer code](#).

If the service is covered by Medicare, then the Tribal FQHC cannot use procedure code T1015.

Topic #24125

Dental Services

Direct and Indirect Dental Services

Services related to direct dental services are typically considered indirect services. For example, depending on the procedure being performed, a radiograph (X-ray) **may or may not** be an indirect service. An X-ray taken as part of a comprehensive exam is considered a direct service, but an X-ray taken during a root canal procedure is considered an indirect service. As an indirect service, the X-ray is not a billable procedure.

If an indirect service is the only service provided during a visit and the CHC or Tribal FQHC bills for that service as an encounter with HCPCS (Healthcare Common Procedure Coding System) code T1015, the claim will deny. Instead, the CHC or Tribal FQHC should bill for the ancillary (indirect) service **without HCPCS code T1015**. The claim detail for the [ancillary service](#) will process in a paid status with a \$0 allowed amount.

Prior Authorization Requirements

Providers must submit claims for multiple visits when an existing PA (prior authorization) request's effective date spans dates before and after a Tribal FQHC is removed from T1015 exemption. Refer to the Multiple Dental Visits section of this topic to determine the appropriate [associated procedure codes](#) for DOS on and after a Tribal FQHC is removed from T1015 exemption.

Tribal FQHC providers must [submit PA](#) requests as required.

Codes designated as associated codes do not require PA. ForwardHealth will deny a PA request submitted for associated codes.

Tribal FQHCs must indicate area of oral cavity [codes](#) on PA requests and claims for encounters on the same DOS for complete maxillary and mandibular dentures. The area of oral cavity codes are:

- ▮ "01" for maxillary.
- ▮ "02" for mandibular.

The claim will deny if the area of oral cavity code isn't indicated on both the PA request and the claim. HCPCS code T1015 is associated with this requirement, even though this code isn't required on the PA.

Multiple Dental Visits

There may be situations where certain dental services require more than one face-to-face visit for completion of the service. When

billing for dental services that require additional visits, Tribal FQHCs must use the appropriate dental procedure codes. Tribal FQHCs must submit all face-to-face visits related to the dental service on a single claim on or after the date of completion or delivery. Tribal FQHCs must submit a single claim for the dental services requiring additional visits as follows:

- ┆ Include the base code and associated code(s) with their respective DOS as separate details.
- ┆ Include HCPCS code T1015, when applicable, for the base code and each associated code per the [PPS and AIR](#) claims submission guidelines.

If a provider would like consideration when a base code is not rendered or a claim is denied (such as when the base code does not meet program requirements for reimbursement), Wisconsin DHS (Department of Health Services) will review each associated code service for compliance.

For example, if a patient stops coming to a dental office before the final denture is delivered, the dental provider can [request to be reimbursed](#) for the accrued lab services. Providers can submit a lab bill to ForwardHealth explaining why the final denture(s) wasn't delivered. If the provider has not submitted a claim for any dental steps yet, they may attach the lab bill to the claim when submitting it.

If the provider has submitted a claim with the dental steps, they may complete an [Adjustment/Reconsideration Request \(F-13046 \(02/2025\)\)](#) form, by checking the "Consultant review requested" box in Element 16 and attaching the lab bill, and submit it to:

BadgerCare Plus
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

ForwardHealth will consider reimbursing providers for the lab fees on a case-by-case basis.

Dental Services That Only Need Base Codes

The following types of codes do not need associated codes and can be used to represent the service once per DOS per member per provider:

- ┆ Denture repair codes
- ┆ Relines (excluding the six-month post-care period)
- ┆ Tooth re-implantation base codes

Dental Services and Face-to-Face Visits

A face-to-face visit is a direct, in-person interaction between a member and a provider that:

- ┆ Requires a condition and/or reason for payment.
- ┆ Results in the provider documenting why the encounter was necessary and what occurred during the encounter.

When billing for dental services that require additional visits, Tribal FQHCs must submit all face-to-face visits related to the dental service on a single claim on or after the date of completion or delivery using associated procedure codes.

Tribal FQHCs must submit a single claim for dental services requiring additional visits and include:

- ┆ The base code and associated code(s) with their respective DOS as separate details.
- ┆ HCPCS code T1015, when applicable, for the base code and each associated procedure code per PPS or AIR claims submission guidelines.
- ┆ Area of oral cavity codes for encounters (indicated by HCPCS code T1015) on the same DOS to provide complete maxillary and complete mandibular dentures.

Note: Procedures that require an area of oral cavity code must be submitted on either the ADA (American Dental Association) 2006 Claim Form, the ADA 2012 Claim Form, or the ADA 2024 Claim Form.

ForwardHealth does not allow global billing under PPS reimbursement for dental services.

Note: ForwardHealth will deny a claim submitted with one claim detail for services given over multiple consecutive days.

Orthodontic and Prosthodontic Services

Tribal FQHCs providing orthodontic and prosthodontic dental services must submit claims for dental procedure codes per visit. ForwardHealth will reimburse Tribal FQHCs an encounter rate for each allowable face-to-face visit for dental services requiring more than one visit under PPS or AIR.

Reimbursement Based on Date of Service

For DOS between January 1, 2024, and the date a Tribal FQHC implemented the PPS or AIR reimbursement model, providers should not indicate the associated procedure code for additional dental visits. These visits will be accounted under the cost-settlement process.

For DOS on and after the date in which a Tribal FQHC implemented the PPS or AIR reimbursement model, providers must indicate the associated procedure code for each additional dental visit as appropriate on a single claim with the base code and associated codes listed as separate details.

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 #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% 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 submission clarification code 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 submission clarification code 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% 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 the UD modifier for each HCPCS (Healthcare Common Procedure Coding System) procedure code. The UD modifier indicates 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 the UD modifier 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 the UD modifier to identify professional claims for drugs purchased through the 340B Program. If the UD modifier 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 #562

HMOs and Managed Care Organizations

Claims for services covered by the member's state-contracted HMO or MCO (managed care organization) should be submitted to the HMO or MCO provider services.

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 \(02/2025\)\)](#) 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										PICA									
1. MEDICARE ☐ MEDICAID ☒ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA ☐ BLK LUNG ☐ OTHER ☐										1a. INSURED'S ID. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
MEMBER, IM A										SAME									
5. PATIENT'S ADDRESS (No., Street)										7. INSURED'S ADDRESS (No., Street)									
609 WILLOW ST																			
CITY										CITY									
ANYTOWN																			
STATE										STATE									
WI																			
ZIP CODE										ZIP CODE									
55555																			
TELEPHONE (Include Area Code)										TELEPHONE (Include Area Code)									
(444) 444-4444																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH									
b. RESERVED FOR NUCC USE										MM DD YY M F									
c. RESERVED FOR NUCC USE										b. OTHER CLAIM ID (Designated by NUCC)									
d. INSURANCE PLAN NAME OR PROGRAM NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME									
10. IS PATIENT'S CONDITION RELATED TO:										d. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
a. EMPLOYMENT? (Current or Previous)										YES NO									
b. AUTO ACCIDENT?										YES NO									
c. OTHER ACCIDENT?										YES NO									
10d. CLAIM CODES (Designated by NUCC)										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
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									
SIGNED										DATE									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION									
MM DD YY QUAL										FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
I.M. REFERRING PROVIDER										FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. XXX.X B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. G. H. I. J. K. L.										F. G. H. I. J. K. L.									
MM DD YY MM DD YY CPT/HCPCS MODIFIER										F. G. H. I. J. K. L.									
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25. FEDERAL TAX ID. NUMBER SSN EIN										27. ACCEPT ASSIGNMENT? YES NO									
1234JED										28. TOTAL CHARGE \$ XXX XX									
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.)										29. AMOUNT PAID \$									
I.M. Provider MMDDCCYY										30. Resd for NUCC Use									
SIGNED DATE										33. BILLING PROVIDER INFO & PH #									
I.M. Provider MMDDCCYY										I.M. PROVIDER									
SIGNED DATE										1 W WILLIAMS ST									
SIGNED DATE										ANYTOWN WI 55555-1234									
SIGNED DATE										a. 0222222220 b. ZZ123456789X									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Sample of an Incorrectly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

☐ PICA ☐ MEDICARE ☒ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA ☐ OTHER		1a. INSURED'S ID. NUMBER 1234567890	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MEMBER, IM A		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME	
5. PATIENT'S ADDRESS (No., Street) 609 WILLOW ST		7. INSURED'S ADDRESS (No., Street)	
3. PATIENT'S BIRTH DATE MM DD YY MM DD YY		6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☒	
8. RESERVED FOR NUCC USE		11. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 55555 (111) 444-4444		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐ b. AUTO ACCIDENT? ☐ YES ☐ NO ☐ c. OTHER ACCIDENT? ☐ YES ☐ NO ☐	
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 _____ DATE _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE MM DD YY QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE I.M. REFERRING PROVIDER		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☐ NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD 10d A. XXX.X B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.	
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 I MODIFIER E. DIAGNOSIS POINTER		F. \$ CHARGES G. DAYS OF UNITS H. ICD 10d I. QUAL J. RENDERING PROVIDER ID. #	
1 MM DD YY XX XXXXX XX X		XXX XX 1	
25. FEDERAL TAX ID. NUMBER SSN EIN 1234JED		27. ACCEPT ASSIGNMENT? YES ☐ NO ☐	
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.) J.M. Provider MMDDCCYY		33. BILLING PROVIDER INFO & PH # I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234 (222) 222-2220 ZZ123456789	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Call 04 246 6160

Sample of an Incorrectly Aligned UB-04 Claim Form

1 IM BILLING PROVIDER 444 E CLAIREMONT ANYTOWN WI 55555-1234 (444) 444-4444		2		3a PAT CNTL # b MED REC # 117654321		4 TYPE OF BILL XXX	
8 PATIENT NAME MEMBER, IM A		9 PATIENT ADDRESS ON FILE		5 FED TAX NO. 01-2345678		6 STATEMENT COVERS PERIOD FROM MMDDCCYY MMDDCCYY	
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACCT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE CODE		33 OCCURRENCE DATE	
34		35 OCCURRENCE DATE		36 OCCURRENCE DATE		37	
38		39 CODE		40 CODE		41 CODE	
42 REV CD		43 DESCRIPTION		44 HCPCS / RATE / HPPS CODE		45 SERV DATE	
46 SERV UNITS		47 TOTAL CHARGES		48 NON COVERED CHARGES		49	
XXXX		XXXX		XXXX		MMDDYY 1.0 XX XX	
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PAGE 1 OF 1		CREATION DATE		TOTALS		XXX XX 0111111110	
50 PAYER NAME T19 MEDICAID		51 HEALTH PLAN ID		52 REL RPD		53 ADD BEN	
54 FIBOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID	
58 INSURED'S NAME SAME		59 PTEL		60 INSURED'S UNIQUE ID 1234567890		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66		67		68		69	
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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 for encounters paid fee for service. This topic does not apply to CHCs (community health centers) subject to [PPS \(prospective payment system\)](#) reimbursement or Tribal FQHCs subject to PPS or [AIR \(all-inclusive rate\)](#) 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 these 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 \(02/2025\)\)](#) 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 \(DMS-1000 \(05/2025\)\)](#) 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 #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 XYZ drug, 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, Z1234. 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
Z1234	12345-6789-12	XYZ drug—100 mg
Z1234	12345-6789-34	XYZ drug—50 mg

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

24. A.	DATE(S) OF SERVICE	B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES	E.	F.	G.	H.	I.	J.
	From To	PLACE OF SERVICE	EMG	(Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS POINT	CHARGES	DATE OF UNITS	UNIT	NO. QUAL.	RENDERING PROVIDER ID. #
1	N412345678912 ME100 11 13 14 11 13 14	11		Z1234 KP	AC	500.00	2	N	NPI	0123456789
2	N412345678934 ME50 11 13 14 11 13 14	11		Z1234 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 ABC drug, 125 mg of XYZ drug, and 50 ml of PRQ drug, 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	11111-2222-33	ABC drug—1 mg
J3490	12345-6789-56	XYZ drug—125 mg
J3490	44444-5555-66	PRQ drug—50 ml

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

24. A.	DATE(S) OF SERVICE						C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E.	F.		G.	H.	I.	J.
	From		To		PLACE OF SERVICE	EMG		CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER		\$ CHARGES	DATE UNITS				
MM	DD	YY	MM	DD	YY												
1	N411111222233	ME1															
	11	13	14	11	13	14	11		J3490	KP		AC	500.00	1	N	NPI	0123456789
2	N412345678956	ME125															
	11	13	14	11	13	14	11		J3490	KQ		AC	500.00	1	N	NPI	0123456789
3	N444444555566	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.

Coordination of Benefits

2

Archive Date:10/01/2026

Coordination of Benefits:Commercial Health Insurance

Topic #595

Assignment of Insurance Benefits

Assignment of insurance benefits is the process by which a specified party (for example, provider or policyholder) becomes entitled to receive payment for claims in accordance with the insurance company policies.

Other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) companies may permit reimbursement to the provider or member. Providers should verify whether other health insurance benefits may be assigned to the provider. As indicated by the other health insurance, providers may be required to obtain approval from the member for this assignment of benefits.

If the provider is assigned benefits, providers should bill the other health insurance.

If the member is assigned insurance benefits, it is appropriate to submit a claim to ForwardHealth without billing the other health insurance. In this instance providers should indicate the appropriate other insurance indicator or complete the [Explanation of Medical Benefits form](#), as applicable. ForwardHealth will bill the other health insurance.

Topic #844

Claims for Services Denied by Commercial Health Insurance

If commercial health insurance denies or recoups payment for services that are covered by BadgerCare Plus and Wisconsin Medicaid, the provider may submit a claim for those services. To allow payment in this situation, providers are encouraged to follow the requirements (for example, request PA (prior authorization) before providing the service for covered services that require PA). If the requirements are followed, ForwardHealth may reimburse for the service up to the allowed amount (less any payments made by other health insurance sources).

Note: The provider is required to demonstrate that a correct and complete claim was denied by the commercial health insurance company for a reason other than that the provider was out of network.

Topic #598

Commercial Fee-for-Service

Fee-for-service commercial health insurance is the traditional health care payment system under which providers receive a payment for each unit of service provided rather than a capitation payment for each member. Such insurance usually does not restrict health care to a particular network of providers.

When commercial health insurance plans give the member the option of getting care within or outside a provider network, non-network providers **may** be reimbursed by the commercial health insurance company for covered services if they follow the commercial health insurance plan's billing rules.

Topic #21978

Coordination of Benefits

For the purposes of this Online Handbook topic:

- ▮ A [PPS \(prospective payment system\)](#) rate applies to CHCs (community health centers) and Tribal FQHCs (federally qualified health centers).
- ▮ An [AIR \(all-inclusive rate\)](#) applies to Tribal FQHCs only.

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

For services rendered between January 1, 2024, and the date when the Tribal FQHC implemented PPS or AIR reimbursement, all payments from commercial health insurance, per encounter type, will be deducted from PPS or AIR, per encounter type, through a reconciliation.

For services rendered after a Tribal FQHC implemented the PPS or AIR model, payments from commercial insurance, per encounter type, will be deducted from PPS or AIR per encounter type authorized by ForwardHealth under HCPCS (Healthcare Common Procedure Coding System) code T1015 up to the PPS rate or AIR.

Note: G0466–G0470 are Medicare codes for FQHC bundled services, similar to the T1015 code with Wisconsin Medicaid. ForwardHealth does not recognize the G-series for fee-for-service claims. However, when G-series codes are on Medicare cross-over claims, ForwardHealth policy provides reimbursement for deductible copay and co-insurance. These codes should not be used in combination with HCPCS code T1015.

For Non-Tribal Members

If applicable, CHCs and Tribal FQHCs must bill a non-Tribal member's commercial health insurance first with all appropriate procedure codes, including HCPCS procedure code T1015. After commercial health insurance has processed a claim, the CHC or Tribal FQHC may submit the claim to ForwardHealth using the same CDT (Current Dental Terminology), CPT (Current Procedural Terminology), or HCPCS procedure codes used on the commercial health insurance claim. CHCs and Tribal FQHCs must indicate the appropriate other insurance information on the claim or include a completed [Explanation of Medical Benefits form](#) if the claim was submitted on paper. CHCs and Tribal FQHCs must submit the commercial health insurance information at the level it was processed by the commercial health insurance (header or detail level).

ForwardHealth will deduct all payments from commercial health insurance from the PPS or AIR per encounter type authorized under HCPCS code T1015.

For Tribal Members

For Tribal members who receive coverage from IHS (Indian Health Services), Wisconsin Medicaid and BadgerCare Plus are not the payer of last resort. Providers should ask members if they have coverage from these other governmental programs.

If a member has Tribal coverage and there is concern about billing Wisconsin Medicaid as the primary due to rejected claims, their provider should [contact their field representative](#).

Topic #601

Definition of Commercial Health Insurance

Commercial health insurance is defined as any type of health benefit not obtained from Medicare or Wisconsin Medicaid and BadgerCare Plus. The insurance may be employer-sponsored or privately purchased. Commercial health insurance may be provided on a fee-for-service basis or through a managed care plan.

Common types of commercial health insurance include HMOs, PPOs (preferred provider organizations), POS (point-of-service) plans, Medicare Advantage plans, Medicare supplemental plans, dental plans, vision plans, HRAs (health reimbursement accounts), and LTC (long term care) plans. Some commercial health insurance providers restrict coverage to a specified group of providers in a particular service area.

When commercial health insurance plans require members to use a designated network of providers, non-network (for example, providers who do not have a contract with the member's commercial health insurance plan) will be reimbursed by the commercial health insurance plan **only** if they obtain a referral or provide an emergency service.

Except for emergency services and covered services that are not covered under the commercial health insurance plan, members enrolled in both a commercial health insurance plan and BadgerCare Plus or Wisconsin Medicaid (for example, state-contracted MCO (managed care organization), fee-for-service) are required to receive services from providers affiliated with the commercial health insurance plan. In this situation, providers are required to refer the members to the commercial health insurance plan's network providers. This is necessary because commercial health insurance is always primary to BadgerCare Plus.

BadgerCare Plus and Wisconsin Medicaid will **not** reimburse the provider if the commercial health insurance plan denied or would deny payment because a service otherwise covered under the commercial health insurance plan was performed by a provider outside the plan. In addition, if a member receives a covered service outside their commercial health insurance plan, the provider cannot collect payment from the member.

Topic #602

Discounted Rates

Providers of services that are discounted by other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) should include the following information on claims or on the [Explanation of Medical Benefits form](#), as applicable:

- ▮ Their [usual and customary charge](#)
- ▮ The appropriate claim adjustment reason code, NCPDP (National Council for Prescription Drug Programs) reject code, or other insurance indicator
- ▮ The amount, if any, actually received from other health insurance as the amount paid by other health insurance

Topic #596

Exhausting Commercial Health Insurance Sources

Providers are required to exhaust commercial health insurance sources before submitting claims to ForwardHealth. This is accomplished by following the process indicated in the following steps. Providers are required to prepare complete and accurate documentation of efforts to bill commercial health insurance to substantiate other insurance indicators used on any claim.

Step 1. Determine if the Member Has Commercial Health Insurance

If Wisconsin's EVS (Enrollment Verification System) does not indicate that the member has commercial health insurance, the provider may submit a claim to ForwardHealth unless the provider is otherwise aware of commercial health insurance coverage.

If the member disputes the information as it is indicated in the EVS, the provider should submit a [real-time Other Coverage Discrepancy Report via the ForwardHealth Portal](#) or submit a completed [Commercial Other Coverage Discrepancy Report \(F-01159 \(04/2017\)\)](#) form. Unless the service does not require other health insurance billing, the provider should allow at least two weeks before proceeding to Step 2.

Step 2. Determine if the Service Requires Other Health Insurance Billing

If the service requires other health insurance billing, the provider should proceed to Step 3.

If the service does not require other health insurance billing, the provider should proceed in one of the following ways:

- ▮ The provider is encouraged to bill commercial health insurance if they believe that benefits are available. Reimbursement from commercial health insurance may be greater than the Medicaid-allowed amount. If billing commercial health insurance first, the provider should proceed to Step 3.
- ▮ The provider may submit a claim without indicating an other insurance indicator on the claim or on the [Explanation of Medical Benefits form](#), as applicable.

The provider may not bill Wisconsin Medicaid and commercial health insurance simultaneously. Simultaneous billing may constitute fraud and interferes with Wisconsin Medicaid's ability to recover prior payments.

Step 3. Identify Assignment of Commercial Health Insurance Benefits

The provider should verify whether commercial health insurance benefits may be assigned to the provider. (As indicated by commercial health insurance, the provider may be required to obtain approval from the member for this assignment of benefits.)

The provider should proceed in one of the following ways:

- ▮ **If the provider is assigned benefits**, the provider should bill commercial health insurance and proceed to Step 4.
- ▮ **If the member is assigned insurance benefits**, the provider may submit a claim (without billing commercial health insurance) using the appropriate other insurance indicator or complete the Explanation of Medical Benefits form, as applicable.

If the commercial health insurance reimburses the member, the provider may collect the payment from the member. If the provider receives reimbursement from Wisconsin Medicaid and the member, the provider is required to return the lesser amount to Wisconsin Medicaid.

Step 4. Bill Commercial Health Insurance and Follow Up

If commercial health insurance denies or partially reimburses the provider for the claim, the provider may proceed to Step 5.

If commercial health insurance does not respond within 45 days, the provider should follow up the original claim with an inquiry to commercial health insurance to determine the disposition of the claim. If commercial health insurance does not respond within 30 days of the inquiry, the provider may proceed to Step 5.

Step 5. Submit Claim to ForwardHealth

If only partial reimbursement is received, if the correct and complete claim is denied by commercial health insurance, or if commercial health insurance does not respond to the original and follow-up claims, the provider may submit a claim to ForwardHealth using the appropriate other insurance indicator or complete the Explanation of Medical Benefits form, as applicable. Commercial remittance information should not be attached to the claim.

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 (for example, retyped or otherwise reformatted) of the Explanation of Medical Benefits form.

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

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

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

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

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

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

Topic #263

Members Unable to Obtain Services Under Managed Care Plan

Sometimes a member's enrollment file shows commercial managed care coverage, but the member is unable to receive services from the managed care plan. Examples of such situations include the following:

- ┆ Children enrolled in a commercial managed care plan by a noncustodial parent if the custodial parent refuses to use the coverage.
- ┆ Members enrolled in a commercial managed care plan who reside outside the service area of the managed care plan.
- ┆ Members enrolled in a commercial managed care plan who enter a nursing facility that limits the member's access to managed care providers.

In these situations, Wisconsin Medicaid will reimburse services covered by both BadgerCare Plus or Medicaid and the commercial managed care plan even though the services are obtained from providers outside the plan.

When submitting claims for these members, providers should do one of the following:

- ┆ Indicate the other insurance information on the [Explanation of Medical Benefits Form](#) for paper claims.
- ┆ Refer to the Wisconsin [PES \(Provider Electronic Solutions\) manual](#) or the appropriate [837 \(837 health care claim\) companion guide](#) to determine the appropriate other insurance indicator for [electronic claims](#).

Topic #604

Non-Reimbursable Commercial Health Insurance Services

Providers are not reimbursed for the following:

- ┆ Services covered by a commercial health insurance plan, except for coinsurance, copay, or deductible
- ┆ Services for which providers contract with a commercial health insurance plan to receive a capitation payment for services

Topic #605

Other Insurance Indicators

Other insurance indicators are used to report results of commercial health insurance billing and to report when existing insurance was not billed according to Wisconsin Medicaid expectations. Providers are required to use these indicators as applicable on professional, institutional, or dental claims or on the [Explanation of Medical Benefits form](#), as applicable, submitted for members with commercial health insurance. The intentional misuse of other insurance indicators to obtain inappropriate reimbursement constitutes fraud.

Other insurance indicators identify the status and availability of commercial health insurance. The indicators allow providers to be reimbursed correctly when the following occur:

- ┆ Commercial health insurance exists, does not apply, or when, for some valid reason, the provider is unable to obtain such reimbursement by reasonable means.
- ┆ Commercial health insurance does not cover the service provided.
- ┆ Full or partial payment was made by commercial health insurance.

Code	Description
OI-P	PAID in part or in full by commercial health insurance, and/or was applied toward the deductible, coinsurance, copay, blood deductible, or psychiatric reduction. Indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance following submission of a correct and complete claim. Do not use

	this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the member has commercial health insurance coverage, but it was not billed for reasons including, but not limited to, the following: ┆ The member denied coverage or will not cooperate. ┆ The provider knows the service in question is not covered by the carrier. ┆ The member's commercial health insurance failed to respond to initial and follow-up claims. ┆ Benefits are not assignable or cannot get assignment. ┆ Benefits are exhausted.

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

Providers should not use other insurance indicators when the following occur:

- ┆ Wisconsin's EVS (Enrollment Verification System) indicates no commercial health insurance for the DOS (date of service).
- ┆ The service does not require other health insurance billing.
- ┆ Claim denials from other payers relating to NPI (National Provider Identifier) and related data should be resolved with that payer and not submitted to ForwardHealth. Payments made in these situations may be recouped.

Documentation Requirements

Providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation of efforts to bill commercial health insurance sources to substantiate other insurance indicators used on any claim, according to Wis. Admin. Code § [DHS 106.02\(9\)\(a\)](#).

Topic #769

Services Requiring Commercial Health Insurance Billing

If ForwardHealth indicates that the member has other commercial health insurance, the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- ┆ Ambulance services, if provided as emergency services
- ┆ Anesthetist services
- ┆ Audiology services, unless provided in a nursing home or SNF (skilled nursing facility)
- ┆ Behavioral treatment
- ┆ Blood bank services
- ┆ Chiropractic services
- ┆ Dental services
- ┆ DME (durable medical equipment) (rental or purchase), prosthetics, and hearing aids if the billed amount is over \$10 per item
- ┆ Home health services (excluding PC (personal care) services)
- ┆ Hospice services
- ┆ Hospital services, including inpatient or outpatient
- ┆ Independent nurse, nurse practitioner, or nurse midwife services

- | Laboratory services
- | Medicare-covered services for members who have Medicare and commercial health insurance
- | In-home mental health/substance abuse treatment services for children (HealthCheck Other Services) rendered by providers at the master's degree level, doctoral level, and psychiatrist level
- | Outpatient mental health/substance abuse services
- | Mental health/substance abuse day treatment services, including child and adolescent day treatment
- | Narcotic treatment services
- | PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services, unless provided in a nursing home or SNF
- | Physician assistant services
- | Physician services, including surgery, surgical assistance, anesthesiology, or any service to a hospital inpatient (however, physician services provided to a woman whose primary diagnosis indicates a high-risk pregnancy do not require commercial health insurance billing)
- | Pharmacy services for members with verified drug coverage
- | Podiatry services
- | PDN (private duty nursing) services
- | Radiology services
- | RHC (rural health clinic) services
- | Skilled nursing home care, if any DOS (date of service) is within 120 days of the date of admission; if benefits greater than 120 days are available, the nursing home is required to continue to bill for them until those benefits are exhausted
- | Vision services over \$50, unless provided in a home, nursing home, or SNF

If ForwardHealth indicates the member has other vision coverage, the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- | Ophthalmology services
- | Optometrist services

If ForwardHealth indicates the member has Medicare supplemental plan coverage, the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- | Alcohol, betadine, and/or iodine provided by a pharmacy or medical vendor
- | Ambulance services
- | Ambulatory surgery center services
- | Breast reconstruction services
- | Chiropractic services
- | Dental anesthesia services
- | Home health services (excluding PC services)
- | Hospital services, including inpatient or outpatient
- | Medicare-covered services
- | Osteopath services
- | Physician services
- | Skilled nursing home care, if any DOS is within 100 days of the date of admission; if benefits greater than 100 days are available, the nursing home is required to continue to bill for them until those benefits are exhausted

ForwardHealth has identified [services requiring Medicare Advantage billing](#).

Medicare

Topic #664

Acceptance of Assignment

In Medicare, **assignment** is a process through which a provider agrees to accept the Medicare-allowed amount as payment in full. A provider who agrees to this amount is said to **accept assignment**.

A Medicare-enrolled provider performing a Medicare-covered service for a dual eligible or [QMB-Only \(Qualified Medicare Beneficiary-Only\)](#) member is required to accept assignment of the member's Medicare Part A benefits. Therefore, Wisconsin Medicaid's total reimbursement for a Medicare Part A-covered inpatient hospital service (for example, any amount paid by other health insurance sources, any copay or deductible amounts paid by the member, and any amount paid by Wisconsin Medicaid or BadgerCare Plus) may not exceed the Medicare-allowed amount.

Topic #666

Claims Denied for Errors

Medicare claims that were denied for provider billing errors must be corrected and resubmitted to Medicare before the claim may be submitted to ForwardHealth.

Topic #668

Claims Processed by Commercial Health Insurance That Is Secondary to Medicare

If a crossover claim is also processed by commercial health insurance that is secondary to Medicare (for example, Medicare supplemental), the claim will not be forwarded to ForwardHealth. After the claim has been processed by the commercial health insurance, the provider should submit a provider-submitted crossover claim to ForwardHealth with the appropriate other insurance indicator or [Explanation of Medical Benefits form](#), as applicable.

Topic #670

Claims That Do Not Require Medicare Billing

For services provided to dual eligibles, professional, institutional, and dental claims should be submitted to ForwardHealth without first submitting them to Medicare in the following situations:

- ▮ The provider cannot be enrolled in Medicare.
- ▮ The service is not allowed by Medicare under any circumstance. Providers should note that claims are denied for services that Medicare has determined are not medically necessary.

In these situations, providers should not indicate a Medicare disclaimer code on the claim.

Topic #704

Claims That Fail to Cross Over

ForwardHealth must be able to identify the billing provider in order to report paid or denied Medicare crossover claims information on the RA (Remittance Advice). Claims with an NPI (National Provider Identifier) that fails to appear on the provider's RA are an indication that there is a problem with the matching and identification of the billing provider and the claims were denied.

ForwardHealth is not able to identify the billing provider on automatic crossover claims submitted by health care providers in the following situations:

- ▮ The billing provider's NPI has not been reported to ForwardHealth.
- ▮ The taxonomy code has not been reported to ForwardHealth or is not indicated on the automatic crossover claim.
- ▮ The billing provider's practice location ZIP+4 code on file with ForwardHealth is required to identify the provider and is not indicated on the automatic crossover claim.

If automatic crossover claims do not appear on the ForwardHealth and/or the MCO's (managed care organization) RA after 30 days of the Medicare processing date, providers are required to resubmit the claim directly to ForwardHealth or the MCO using the NPI that was reported to ForwardHealth as the primary NPI. Additionally, the taxonomy code and the ZIP+4 code of the practice location on file with ForwardHealth are required when additional data is needed to identify the provider.

Topic #667

Claims for Services Denied by Medicare

If Medicare denies or recoups payment for services provided to dual eligibles that are covered by BadgerCare Plus or Wisconsin Medicaid, the provider may submit a claim for those services directly to ForwardHealth. To allow payment by ForwardHealth in this situation, providers are encouraged to follow BadgerCare Plus and Medicaid requirements (for example, request PA (prior authorization) before providing the service for covered services that require PA). If the requirements are followed, ForwardHealth may reimburse for the service up to the allowed amount (less any payments made by other health insurance sources).

Topic #671

Crossover Claims

A Medicare crossover claim is a Medicare-allowed claim for a dual eligible or QMB-Only (Qualified Medicare Beneficiary-Only) member sent to ForwardHealth for payment of coinsurance, copay, and deductible.

Submit Medicare claims first, as appropriate, to one of the following:

- ▮ Medicare Part A fiscal intermediary
- ▮ Medicare Part B carrier
- ▮ Medicare DME (durable medical equipment) regional carrier
- ▮ Medicare Advantage Plan or Medicare Cost Plan
- ▮ Railroad Retirement Board carrier (also known as the Railroad Medicare carrier)

There are two types of crossover claims based on who submits them:

- ▮ Automatic crossover claims

- Provider-submitted crossover claims

Automatic Crossover Claims

An automatic crossover claim is a claim that Medicare automatically forwards to ForwardHealth by the COBC (Coordination of Benefits Contractor).

Claims will be forwarded if the following occur:

- Medicare has identified that the services were provided to a dual eligible or a QMB-Only member.
- The claim is for a member who is not enrolled in a Medicare Advantage Plan.

Providers are advised to wait 30 days before billing for claims submitted to Medicare to allow time for the automatic crossover process to complete. If automatic crossover claims do not appear on the ForwardHealth and/or the MCO (managed care organization)'s RA (Remittance Advice) after 30 days of the Medicare processing date, providers are required to resubmit the claim directly to ForwardHealth or the MCO using the NPI (National Provider Identifier) that was reported to ForwardHealth as the primary NPI.

If the service is covered by the MCO, the ForwardHealth RA will indicate EOB (Explanation of Benefits) code 0287 (Member is enrolled in a State-contracted managed care program). If the service is covered on a fee-for-service basis, the MCO RA will indicate that the service is not covered. If the crossover claim is submitted without error, the responsible entity (either ForwardHealth or the MCO) will process the claim to a payable status.

Provider-Submitted Crossover Claims

A provider-submitted crossover claim is a Medicare-allowed claim that a provider directly submits to ForwardHealth when the Medicare claim did not automatically cross over. Providers should submit a provider-submitted crossover claim in the following situations:

- The automatic crossover claim does not appear on the ForwardHealth or MCO RA within 30 days of the Medicare processing date.
- The automatic crossover claim is denied, and additional information may allow payment.
- The claim is for a member who was not enrolled in BadgerCare Plus or Wisconsin Medicaid at the time the service was submitted to Medicare for payment, but the member was retroactively determined enrolled in BadgerCare Plus or Medicaid.
- The claim is for a member who is enrolled in a Medicare Advantage Plan or Medicare Cost Plan.
- The claim is for a member who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (for example, Medicare Supplemental).

When submitting crossover claims directly, the following additional data may be required on the claim to identify the billing and rendering provider:

- The NPI that ForwardHealth has on file for the provider
- The taxonomy code that ForwardHealth has on file for the provider
- The ZIP+4 code that corresponds to the practice location address on file with ForwardHealth

Providers may initiate a provider-submitted claim in one of the following ways:

- DDE (Direct Data Entry) through the ForwardHealth Provider Portal
- 837I (837 Health Care Claim: Institutional) transaction, as applicable
- 837P (837 Health Care Claim: Professional) transaction, as applicable
- PES (Provider Electronic Solutions) software

- ┆ Paper claim form

Topic #672

Definition of Medicare

Medicare is a health insurance program for people 65 years of age or older, for certain people with disabilities under age 65, and for people with ESRD (end-stage renal disease). Medicare is a federal government program created under Title XVIII of the Social Security Act.

Medicare coverage is divided into four parts:

- ┆ Part A (Hospital Insurance). Part A helps to pay for medically necessary services, including inpatient hospital services, services provided in critical access hospitals (for example, small facilities that give limited inpatient services and outpatient services to beneficiaries who reside in rural areas), services provided in skilled nursing facilities, hospice services, and some home health services.
- ┆ Part B (Supplemental Medical Insurance). Part B helps to pay for medically necessary services, including physician services, outpatient hospital services, and some other services that Part A does not cover (such as PT (physical therapy) services, OT (occupational therapy) services, and some home health services).
- ┆ Part C (Medicare Advantage). A commercial health plan that acts for Medicare Parts A and B, and sometimes Medicare Part D, for all Medicare covered services except hospice. Medicare Part A continues to provide coverage for hospice services. There are limitations on coverage outside of the carrier's provider network.
- ┆ Part D (drug benefit).

Topic #684

Dual Eligibles

Dual eligibles are members who are eligible for coverage from Medicare (either Medicare Part A, Part B, or both) **and** Wisconsin Medicaid or BadgerCare Plus.

Dual eligibles may receive coverage for the following:

- ┆ Medicare monthly premiums for Part A, Part B, or both
- ┆ Coinsurance, copay, and deductible for Medicare-allowed services
- ┆ BadgerCare Plus or Medicaid-covered services, even those that are not allowed by Medicare

Topic #669

Exhausting Medicare Coverage

Providers are required to exhaust Medicare coverage before submitting claims to ForwardHealth. This is accomplished by following these instructions. Providers are required to prepare complete and accurate documentation of efforts to bill Medicare to substantiate Medicare disclaimer codes used on any claim.

Adjustment Request for Crossover Claim

The provider may submit a paper or electronic adjustment request. If submitting a paper [Adjustment/Reconsideration Request \(F-13046 \(02/2025\)\)](#) form, the provider should complete and submit the [Explanation of Medical Benefits form](#), as applicable.

Provider-Submitted Crossover Claim

The provider may submit a provider-submitted crossover claim in the following situations:

- ┆ The automatic crossover claim is not processed by ForwardHealth within 30 days of the Medicare processing date.
- ┆ ForwardHealth denied the automatic crossover claim, and additional information may allow payment.
- ┆ The claim is for a member who is enrolled in a Medicare Advantage Plan.
- ┆ The claim is for a member who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (**for example**, Medicare Supplemental).
- ┆ The claim is for a member who was not enrolled in BadgerCare Plus at the time the service was submitted to Medicare for payment, but the member was retroactively enrolled.*

When submitting provider-submitted crossover claims, the provider is required to follow all claims submission requirements in addition to the following:

- ┆ For electronic claims, indicate the Medicare payment.
- ┆ For paper claims, complete the [Explanation of Medical Benefits form](#).

When submitting provider-submitted crossover claims for members enrolled in Medicare and commercial health insurance that is secondary to Medicare, the provider is also required to do the following:

- ┆ Refrain from submitting the claim to ForwardHealth until after the claim has been processed by the commercial health insurance.
- ┆ Indicate the appropriate other insurance indicator on the claim or the [Explanation of Medical Benefits form](#), as applicable.

* In this situation, a timely filing appeals request may be submitted if the services provided are beyond the claims submission deadline. The provider is required to indicate "retroactive enrollment" on the provider-submitted crossover claim and submit the claim with the [Timely Filing Appeals Request \(F-13047 \(08/2015\)\)](#) form and [Explanation of Medical Benefits form](#), as applicable. The provider is required to submit the timely filing appeals request within 180 days from the date the backdated enrollment was added to the member's file.

Claim for Services Denied by Medicare

When Medicare denies payment for a service provided to a dual eligible that is covered by BadgerCare Plus or Wisconsin Medicaid, the provider may proceed as follows:

- ┆ Bill commercial health insurance, if applicable.
- ┆ Submit a claim to ForwardHealth using the appropriate Medicare disclaimer code. If applicable, the provider should indicate the appropriate other insurance indicator on the claim or the [Explanation of Medical Benefits form](#), as applicable. A copy of Medicare remittance information should not be attached to the claim.

Crossover Claim Previously Reimbursed

A crossover claim may have been previously reimbursed by Wisconsin Medicaid when one of the following has occurred:

- ┆ Medicare reconsiders services that were previously not allowed.
- ┆ Medicare retroactively determines a member eligible.

In these situations, the provider should proceed as follows:

- ┆ Refund or adjust Medicaid payments for services previously reimbursed by Wisconsin Medicaid.

- Bill Medicare for the services and follow ForwardHealth's procedures for submitting crossover claims.

Topic #687

Medicare Advantage

Medicare services may be provided to dual eligibles or QMB-Only (Qualified Medicare Beneficiary-Only) members on a fee-for-service basis or through a Medicare Advantage Plan. Medicare Advantage Plans have a special arrangement with the federal CMS (Centers for Medicare and Medicaid Services) and agree to provide all Medicare benefits to Medicare beneficiaries for a fee. Providers may contact Medicare for a list of Medicare Advantage Plans in Wisconsin and the insurance companies with which they are associated.

ForwardHealth has identified [services requiring Medicare Advantage billing](#).

Paper Crossover Claims

Providers are required to complete and submit an [Explanation of Medical Benefits form](#), along with provider-submitted paper crossover claims for services provided to members enrolled in a Medicare Advantage Plan.

Reimbursement Limits

Reimbursement limits on Medicare Part B services are applied to all Medicare Advantage Plan copay amounts in accordance with federal law. This may reduce reimbursement amounts in some cases.

Topic #20677

Medicare Cost

Providers are required to bill the following services to the Medicare Cost Plan before submitting claims to ForwardHealth if the member was enrolled in the Medicare Cost Plan at the time the service was provided:

- Ambulance services
- ASC (ambulatory surgery center) services
- Chiropractic services
- Dental anesthesia services
- Home health services (excluding PC (personal care) services)
- Hospital services, including inpatient or outpatient
- Medicare-covered services
- Osteopath services
- Physician services

Providers who are not within the member's Medicare Cost network and are not providing an emergency service or Medicare-allowed service with a referral may submit a claim to traditional Medicare Part A or Medicare Part B for the Medicare-allowed service prior to billing ForwardHealth.

Topic #688

Medicare Disclaimer Codes

Medicare disclaimer codes are used to ensure consistent reporting of common billing situations for dual eligibles. Refer to claim instructions for Medicare disclaimer codes and their descriptions. The intentional misuse of Medicare disclaimer codes to obtain inappropriate reimbursement from ForwardHealth constitutes fraud.

Medicare disclaimer codes identify the status and availability of Medicare benefits. The code allows a provider to be reimbursed correctly by ForwardHealth when Medicare benefits exist or when, for some valid reason, the provider is unable to obtain such benefits by reasonable means.

When submitting a claim for a covered service that was denied by Medicare, providers should resubmit the claim **directly** to ForwardHealth using the appropriate Medicare disclaimer code on the claim or the [Explanation of Medical Benefits form](#), as applicable.

Code	Description
M-7	Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, or yearly allotment of available benefits is exhausted. For Medicare Part A, use M-7 in the following instances (all three criteria must be met): ▮ The provider is identified in ForwardHealth files as enrolled in Medicare Part A. ▮ The member is eligible for Medicare Part A. ▮ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or exhausted benefits. For Medicare Part B, use M-7 in the following instances (all three criteria must be met): ▮ The provider is identified in ForwardHealth files as enrolled in Medicare Part B. ▮ The member is eligible for Medicare Part B. ▮ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or exhausted benefits.
M-8	Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. For Medicare Part A, use M-8 in the following instances (all three criteria must be met): ▮ The provider is identified in ForwardHealth files as enrolled in Medicare Part A. ▮ The member is eligible for Medicare Part A. ▮ The service is usually covered by Medicare Part A but not in this circumstance (for example, member's diagnosis). For Medicare Part B, use M-8 in the following instances (all three criteria must be met): ▮ The provider is identified in ForwardHealth files as enrolled in Medicare Part B. ▮ The member is eligible for Medicare Part B. ▮ The service is usually covered by Medicare Part B but not in this circumstance (for example, member's diagnosis).

Documentation Requirements

Providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation of efforts to bill Medicare to substantiate Medicare disclaimer codes used on any claim, according to Wis. Admin. Code [§ DHS 106.02\(9\)\(a\)](#).

Topic #8457

Medicare Late Fees

Medicare assesses a late fee when providers submit a claim after Medicare's claim submission deadline has passed. Claims that cross over to ForwardHealth with a Medicare late fee are denied for being out of balance. To identify these claims, providers should reference the Medicare remittance information and check for ANSI (American National Standards Institute) code B4 (late filing penalty), which indicates a late fee amount deducted by Medicare.

ForwardHealth considers a late fee part of Medicare's paid amount for the claim because Medicare would have paid the additional amount if the claim had been submitted before the Medicare claim submission deadline. ForwardHealth will not reimburse providers for late fees assessed by Medicare.

Resubmitting Medicare Crossover Claims with Late Fees

Providers may resubmit to ForwardHealth crossover claims denied because the claim was out of balance due to a Medicare late fee. The claim may be submitted on paper, submitted electronically using the ForwardHealth Portal, or submitted as an 837 (837 Health Care Claim) transaction.

Paper Claim Submissions

When resubmitting a crossover claim on paper, include a copy of the Medicare remittance information so ForwardHealth can determine the amount of the late fee and apply the correct reimbursement amount.

Electronic Claim Submissions

When resubmitting a claim via the Portal or an electronic 837 transaction (including PES (Provider Electronic Solutions) software submissions), providers are required to balance the claim's paid amount to reflect the amount Medicare would have paid before Medicare subtracted a late fee. This is the amount that ForwardHealth considers when adjudicating the claim. To balance the claim's paid amount, add the late fee to the paid amount reported by Medicare. Enter this amount in the Medicare paid amount field.

For example, the Medicare remittance information reports the following amounts for a crossover claim:

- | Billed Amount: \$110
- | Allowed Amount: \$100
- | Coinsurance: \$20
- | Late Fee: \$5
- | Paid Amount: \$75

Since ForwardHealth considers the late fee part of the paid amount, providers should add the late fee to the paid amount reported on the Medicare remittance. In the example above, add the late fee of \$5 to the paid amount of \$75 for a total of \$80. The claim should report the Medicare paid amount as \$80.

Topic #689

Medicare Provider Enrollment

Some providers may become retroactively enrolled in Medicare. Providers should contact Medicare for more information about retroactive enrollment.

Services for Dual Eligibles

As stated in Wis. Admin. Code § [DHS 106.03\(7\)](#), a provider is required to be enrolled in Medicare if both of the following are true:

- ▮ They provide a Medicare Part A service to a dual eligible.
- ▮ They can be enrolled in Medicare.

If a provider can be enrolled in Medicare but chooses **not** to be, the provider is required to refer dual eligibles to another Medicaid-enrolled provider who is enrolled in Medicare.

Services for Qualified Medicare Beneficiary-Only Members

Because QMB-Only (Qualified Medicare Beneficiary-Only) members receive coverage from Wisconsin Medicaid only for services allowed by Medicare, providers who are not enrolled in Medicare are required to refer QMB-Only members to another Medicaid-enrolled provider who is enrolled in Medicare.

Topic #690

Medicare Retroactive Eligibility — Member

If a member becomes retroactively eligible for Medicare, the provider is required to refund or adjust any payments for the retroactive period. The provider is required to then bill Medicare for the services and follow ForwardHealth's procedures for submitting crossover claims. Claims found to be in conflict with this program requirement will be recouped.

Topic #895

Modifier for Catastrophe/Disaster-Related Crossover Claims

ForwardHealth accepts modifier CR (Catastrophe/disaster related) on Medicare crossover claims (both [837P](#) (837 Health Care Claim: Professional) transactions and 1500 Health Insurance Claim Forms) to accommodate the emergency health care needs of dual eligibles and QMB-Only (Qualified Medicare Beneficiary-Only) members affected by disasters. The [CMS \(Centers for Medicare and Medicaid Services\) website](#) contains more information.

Topic #4957

Provider-Submitted Crossover Claims

A provider-submitted crossover claim is a Medicare-allowed claim that a provider directly submits to ForwardHealth when the

Medicare claim did not automatically crossover to ForwardHealth.

Electronic Professional Crossover Claims

Providers submitting crossover claims electronically must indicate all Medicare coinsurance, copay, and psychiatric reduction amounts at the detail level. If the Medicare coinsurance, copay, and psychiatric reduction amounts are indicated at the header level, the claim will be denied. Providers may indicate deductibles in either the header or detail level.

When submitting electronic Medicare crossover claims, providers should not submit paper EOMB (Explanation of Medicare Benefits) as an attachment. Providers should, however, be sure to complete Medicare CAS segments when submitting 837 (837 Health Care Claim) transactions.

Paper Professional Crossover Claims

All paper provider-submitted crossover claims submitted on the 1500 Health Insurance Claim Form ((02/12)) require a provider signature and date in Item Number 31. The words "signature on file" are not acceptable. Provider-submitted crossover claims without a signature or date are denied or are subject to recoupment. The provider signature requirement for paper crossover claims is the same requirement for all other paper 1500 Health Insurance Claims.

In addition, when submitting a paper provider-submitted crossover claim, providers are required to complete and submit an [Explanation of Medical Benefits form](#), as applicable.

Topic #692

Qualified Medicare Beneficiary-Only Members

QMB-Only (Qualified Medicare Beneficiary-Only) members are a limited benefit category of Medicaid members. They are eligible for coverage from Medicare (either Part A, Part B, or both) **and** limited coverage from Wisconsin Medicaid. QMB-Only members receive Medicaid coverage for the following:

- ┆ Medicare monthly premiums for Part A, Part B, or both
- ┆ Coinsurance, copay, and deductible for Medicare-allowed services

QMB-Only members do not receive coverage from Wisconsin Medicaid for services not allowed by Medicare. Therefore, Wisconsin Medicaid will not reimburse for services if either of the following occur:

- ┆ Medicare does not cover the service.
- ┆ The provider is not enrolled in Medicare.

Topic #686

Reimbursement for Crossover Claims

Professional Crossover Claims

State law limits reimbursement for coinsurance and copay of Medicare Part B-covered services provided to dual eligibles and QMB-Only (Qualified Medicare Beneficiary-Only) members.

Total payment for a Medicare Part B-covered service (for example, any amount paid by other health insurance sources, any copay or spenddown amounts paid by the member, and any amount paid by Wisconsin Medicaid) may not exceed the Medicare-

allowed amount. Therefore, Medicaid reimbursement for coinsurance or copay of a Medicare Part B-covered service is the lesser of the following:

- ▮ The **Medicare**-allowed amount less any amount paid by other health insurance sources and any copay or spenddown amounts paid by the member.
- ▮ The **Medicaid**-allowed amount less any amount paid by other health insurance sources and any copay or spenddown amounts paid by the member.

The following table provides three examples of how the limitations are applied.

Reimbursement for Coinsurance or Copay of Medicare Part B-Covered Services			
Explanation	Example		
	1	2	3
Provider's billed amount	\$120	\$120	\$120
Medicare-allowed amount	\$100	\$100	\$100
Medicaid-allowed amount (for example, maximum allowable fee)	\$90	\$110	\$75
Medicare payment	\$80	\$80	\$80
Medicaid payment	\$10	\$20	\$0

Outpatient Hospital Crossover Claims

Detail-level information is used to calculate pricing for all outpatient hospital crossover claims and adjustments. Details that Medicare paid in full or that Medicare denied in full will not be considered when pricing outpatient hospital crossover claims. Medicare deductibles are paid in full.

Inpatient Hospital Services

State law limits reimbursement for coinsurance, copay and deductible of Medicare Part A-covered inpatient hospital services for dual eligibles and QMB-Only members.

Wisconsin Medicaid's total reimbursement for a Medicare Part A-covered inpatient hospital service (for example, any amount paid by other health insurance sources, any copay or deductible amounts paid by the member, and any amount paid by Wisconsin Medicaid or BadgerCare Plus) may not exceed the Medicare-allowed amount. Therefore, Medicaid reimbursement for coinsurance, copay, and deductible of a Medicare Part A-covered inpatient hospital service is the **lesser** of the following:

- ▮ The difference between the **Medicaid**-allowed amount and the **Medicare**-paid amount.
- ▮ The sum of Medicare coinsurance, copay, and deductible.

The following table provides three examples of how the limitations are applied.

Reimbursement for Medicare Part A-Covered Inpatient Hospital Services Provided To Dual Eligibles			
Explanation	Example		
	1	2	3
Provider's billed amount	\$1,200	\$1,200	\$1,200
Medicare-allowed amount	\$1,000	\$1,000	\$1,000
Medicaid-allowed amount (for example, diagnosis-related group or per diem)	\$1,200	\$750	\$750
Medicare-paid amount	\$1,000	\$800	\$500
Difference between Medicaid-allowed amount and Medicare-paid amount	\$200	(\$-50)	\$250

Medicare coinsurance, copay and deductible	\$0	\$200	\$500
Medicaid payment	\$0	\$0	\$250

Nursing Home Crossover Claims

Medicare deductibles, coinsurance, and copays are paid in full.

Community Health Center and Tribal Federally Qualified Health Center Crossover Claims

CHC (Community health center) and Tribal FQHC (federally qualified health center) encounters subject to [PPS \(prospective payment system\)](#) and [AIR \(all-inclusive rate\)](#) reimbursement are carved out of (not included in) [Medicare Crossover coverage](#).

Topic #4977

Rendering Provider on Professional Crossover Claims

Providers are required to indicate the rendering provider on electronic and paper crossover claims when ForwardHealth service-specific policy requires a rendering provider. However, professional crossover claims received by ForwardHealth from Medicare may not have the taxonomy code of the billing provider indicated on the transaction. Medicare will not accept the 837P (837 Health Care Claim: Professional) transaction when a taxonomy code is reported in both the Billing/Pay-to Provider Loop and in the Rendering Provider Loop if the billing and rendering providers are different. For example, a transaction with a physician group indicated as the billing provider and the individual physician indicated as the rendering provider.

Providers should resubmit professional crossover claims to ForwardHealth when the taxonomy code is required to identify the billing provider and it is not indicated on the crossover claim received from Medicare. Taxonomy codes for billing and rendering providers may be required if the provider has a single NPI for multiple ForwardHealth provider enrollments. Providers should refer to the [837 companion guides](#) for information on using taxonomy codes on standard claim transactions. ForwardHealth will accept the 837P transaction when a taxonomy code is reported in both the Billing/Pay-to Provider Loop and in the Rendering Provider Loop and the billing and rendering providers are different.

This ForwardHealth requirement is inconsistent with the instructions in the 837P Implementation Guide; however, the federal CMS (Centers for Medicare & Medicaid Services) has acknowledged that health plans may need the billing provider taxonomy in order to accurately process claims.

Topic #770

Services Requiring Medicare Advantage Billing

Providers are required to bill the following services to the Medicare Advantage Plan before submitting claims to ForwardHealth:

- | Ambulance services
- | ASC (ambulatory surgery center) services
- | Chiropractic services
- | Dental anesthesia services
- | Home health services (excluding PC (personal care) services)
- | Hospital services, including inpatient or outpatient
- | Medicare-covered services
- | Osteopath services

- Physician services

Providers who are not within the member's Medicare Advantage network and are not providing an emergency service or Medicare-allowed service with a referral are required to refer the member to a provider within their network.

ForwardHealth has identified [services requiring commercial health insurance billing](#).

Other Coverage Information

Topic #4940

After Reporting Discrepancies

After receiving a [Commercial Other Coverage Discrepancy Report \(F-01159 \(04/2017\)\)](#) form or [Medicare Other Coverage Discrepancy Report \(F-02074 \(04/2018\)\)](#) form, ForwardHealth confirms the information and updates the member files.

It may take up to two weeks to process and update the member's enrollment information. During that time, ForwardHealth verifies the insurance information submitted and adds, changes, or removes the member's other coverage information as appropriate. If verification contradicts the provider's information, a written explanation is sent to the provider. The provider should wait to submit claims until one of the following occurs:

- ▮ The provider verifies through Wisconsin's EVS (Enrollment Verification System) that the member's other coverage information has been updated.
- ▮ The provider receives a written explanation.

Topic #4941

Coverage Discrepancies

Maintaining complete and accurate insurance information may result in fewer claim denials. Providers are an important source of other coverage information as they are frequently the first to identify coverage discrepancies.

Topic #609

Insurance Disclosure Program

ForwardHealth receives policyholder files from most major commercial health insurance companies on a monthly basis. ForwardHealth then compares this information with member enrollment files. If a member has commercial health insurance, ForwardHealth revises the member's enrollment file with the most current information.

The insurance company is solely responsible for the accuracy of this data. If the insurance company provides information that is not current, ForwardHealth's files may be inaccurate.

Topic #610

Maintaining Accurate and Current Records

ForwardHealth uses many sources of information to keep accurate and current records of a member's other coverage, including the following:

- ▮ Insurance Disclosure program
- ▮ Providers who submit an [Commercial Other Coverage Discrepancy Report \(F-01159 \(04/2017\)\)](#) form or [Medicare Other Coverage Discrepancy Report \(F-02074 \(04/2018\)\)](#) form

- ┆ Member certifying agencies
- ┆ Members

The information about a member's other health insurance coverage in the member files may be incomplete or incorrect if ForwardHealth received inaccurate information from the other health insurance source or the member's certifying agency.

Topic #4942

Reporting Discrepancies

Providers are encouraged to report discrepancies to ForwardHealth by submitting the [Commercial Other Coverage Discrepancy Report \(F-01159 \(04/2017\)\)](#) form or [Medicare Other Coverage Discrepancy Report \(F-02074 \(04/2018\)\)](#) form. Providers are asked to complete the form in the following situations:

- ┆ The provider is aware of other coverage information that is not indicated by Wisconsin's EVS (Enrollment Verification System).
- ┆ The provider received other coverage information that contradicts the information indicated by the EVS.
- ┆ A claim is denied because the EVS indicates commercial managed care coverage but the coverage is not available to the member (for example, the member does not live in the plan's service area).

Providers should not use the Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form to update any information regarding a member's coverage in a state-contracted MCO (managed care organization).

When reporting discrepancies, providers should include photocopies of current insurance cards and any available documentation, such as remittance information and benefit coverage dates or denials.

Covered and Noncovered Services

3

Archive Date:10/01/2026

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 for encounters paid fee for service. This document does not apply to CHCs (community health centers) subject to [PPS \(prospective payment system\)](#) reimbursement or Tribal FQHCs subject to PPS or [AIR \(all-inclusive rate\)](#) 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 #21977

Associated Procedure Codes for Additional Dental Visits

For reimbursement to CHCs (community health centers) and Tribal FQHCs (federally qualified health centers) for dental services requiring multiple visits, the procedure code that represents the final prosthesis or dental service is referred to as the base procedure code, and each additional visit is referred to as the associated procedure code. Base procedure codes and associated procedure codes will be considered [direct services](#) for [PPS \(prospective payment system\)](#) reimbursement purposes.

ForwardHealth has identified the following CDT (Current Dental Terminology) procedure codes to represent the associated procedure codes:

- ▮ **D1999** (unspecified preventive procedure, by report): This procedure code is for preventive services that require additional visits. Coverage is limited to a maximum of 1 unit per member per preventive procedure.
- ▮ **D2999** (unspecified restorative procedure, by report): This procedure code is for restorative services that require additional visits. Coverage is limited to a maximum of 1 allowable unit per member per restorative procedure.
- ▮ **D3999** (unspecified endodontic procedure, by report): This procedure code is for endodontic services that require additional visits. Coverage is limited to a maximum of 1 allowable unit per member per endodontic procedure.
- ▮ **D5899** (unspecified removable prosthodontic procedure, by report): This procedure code is for complete and partial denture services that require additional visits. Coverage is limited to a maximum of 4 allowable units per member per denture procedure.

Note: Providers are required to document the specific service(s) performed for each dental visit in the member's dental record.

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
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–	Malignant neoplasm of

				C50.829	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*–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
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 ^{**} – L97.529 ^{**}	Non-pressure chronic ulcer 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*– 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

* 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, E13.621, 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 #22057

Encounters Procedure Code

CHCs (community health centers) and Tribal FQHCs (federally qualified health centers) will identify [encounters](#) on claims by using HCPCS (Healthcare Common Procedure Coding System) procedure code T1015 (Clinic visit/encounter, all-inclusive) for services rendered. ForwardHealth assigns the appropriate encounter type to the claim detail associated with procedure code T1015 based on the provider type of the rendering provider.

Topic #24143

Required Codes for Complete Dentures

For complete maxillary and complete mandibular dentures, CHCs and Tribal FQHCs must indicate [area of oral cavity codes](#) on PA (prior authorization) requests and claims for encounters on the same DOS (date of service).

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
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (for example, by airflow or peripheral arterial tone), and sleep time
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, respiratory analysis (for example, by airflow or peripheral arterial tone)
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 (for example, 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
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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 denied. 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 provider uses a code that is not valid, ForwardHealth will deny the claim.

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 (contain the highest number of characters) required by the code set. For some codes, this could be as few as three characters. If a provider uses an ICD diagnosis code that is not valid (not to the specific number of characters required), ForwardHealth will deny the claim.

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 the supervision of a qualified health care professional.

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 three-five 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 qualified health care professional's report with interpretation and findings based on information obtained during monitoring.

Personal Continuous Glucose Monitoring (Purchased for Individual Member)

ForwardHealth covers personal continuous glucose monitors and supplies for members who are diagnosed with any type of diabetes, excluding pre-diabetes, when ForwardHealth requirements are met. Continuous glucose monitors and supplies are covered under ForwardHealth's DME (durable medical equipment) benefit.

Providers may prescribe age-appropriate personal glucose monitors and supplies for both adult and child members (including infants and toddlers) who are diagnosed with any type of diabetes, excluding pre-diabetes.

Coverage Requirements

Providers may prescribe continuous glucose monitors and supplies for members with diabetes who meet all these criteria:

- ▮ The member is under the care of a qualified health care professional who is managing the member's diabetes.
- ▮ The member has a diagnosis of any type of diabetes, excluding pre-diabetes.
- ▮ The member or the member's caregiver has the cognitive ability to be educated about the device, the willingness to use the device, and the physical capability to use the device.
- ▮ The prescription is written by a qualified health care professional who is managing the member's diabetes, is dated within the last 12 months, and includes the name of the prescribed continuous glucose monitor.
- ▮ The member has a diabetic treatment plan ordered by a qualified health care professional who is managing the member's diabetes.
- ▮ The prescribed continuous glucose monitor is appropriate for the member's age.

These criteria must be documented in the member's medical record and provided to the Wisconsin DHS (Department of Health Services) upon request.

Note: There are situations where [PA is required](#) for coverage of continuous glucose monitors. In addition, HMOs can still require PA for continuous glucose monitors.

Allowable Procedure Codes

The following HCPCS (Healthcare Common Procedure Coding System) procedure codes are allowable for personal continuous glucose monitoring devices and supplies:

- ▮ A4239 (Supply allowance for non-adjunctive, non-implanted continuous glucose monitor [cgm], includes all supplies and accessories, 1 month supply = 1 unit of service)
- ▮ 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)
- ▮ E2103 (Non-adjunctive, non-implanted continuous glucose monitor or receiver)

Note: Providers should use the KX modifier when billing for members who are insulin treated, and providers should use the KS modifier when billing for members who are non-insulin treated. In cases where PA is required, DME vendors should indicate procedure codes E2103 or A9278. For more information, refer to the [DMS \(disposable medical supplies\) Index](#).

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 #21958

Encounters

Unless otherwise stated, for the purposes of this Online Handbook topic:

- ┆ A [PPS \(prospective payment system\)](#) rate applies to CHCs (community health centers) and Tribal FQHCs (federally qualified health centers).
- ┆ An [AIR \(all-inclusive rate\)](#) applies to Tribal FQHCs only.

Community Health Centers

A CHC encounter is defined as a face-to-face visit on a single DOS (date of service) between a member and a Medicaid-enrolled CHC provider to provide diagnosis, treatment, or preventive service(s) at the CHC HRSA (Health Resources & Services Administration)-approved location including main and off-site locations. Under PPS, ForwardHealth reimburses CHCs a PPS rate for each allowable CHC encounter.

Tribal FQHCs

Per State Plan Amendment WI 24-0008, a Tribal FQHC encounter is a qualifying visit between a client and a qualified Medicaid Tribal FQHC provider who delivers a Medicaid-covered medical, dental, and/or behavioral ambulatory service on a single day at an approved Tribal FQHC location (including main and off-site locations) for a diagnosis, treatment, or preventative service. Only one medical, one dental, and one mental health encounter will be paid per member per day.

Outpatient Encounters

ForwardHealth considers a service as an encounter when it is:

- ┆ Performed in a CHC or Tribal FQHC location.
- ┆ Performed by a CHC or Tribal FQHC provider in a location such as:
 - ┆ Ambulatory surgical centers
 - ┆ Extended care facilities
 - ┆ Hospitals
 - ┆ Members' homes
 - ┆ Mobile units
 - ┆ Primary sites of rendering providers (dentists contracted to provide services at FQHCs)
 - ┆ School visits

The [interactive maximum allowable fee schedules](#) has all allowable POS (place of service) codes.

All services provided as part of the CHC or Tribal FQHC encounter must meet all applicable ForwardHealth program requirements, including medical necessity, PA (prior authorization), [claims submission](#), prescription requirements, and documentation requirements.

Each CHC or Tribal FQHC encounter is classified as either a medical, dental, or mental health encounter based on the provider type of the rendering provider. Encounters include:

- ┆ Direct services—These are core services provided during the encounter. For example, preventive or routine office visits are direct services.
- ┆ Indirect services—These are supplies and/or diagnostic or therapeutic ancillary services that are delivered as part of the core service(s) provided during the encounter. Indirect services include radiology, laboratory tests, medical supplies, durable medical equipment, ancillary provider services, and professional dispensing fees.

When a Tribal FQHC member is referred to a provider, that provider may only submit a claim for a Tribal FQHC service or encounter if they are under contract with a Tribal FQHC **and** the Tribal FQHC pays for the service.

Indirect Services

Indirect services are Medicaid-covered services that support core services provided during the encounter, but they do not count as individual encounters on their own.

Costs of allowable indirect services are included as a portion of the total cost in the PPS and AIR-setting method.

Indirect costs not allowed under cost-based reimbursement are not included in PPS or AIR.

Note: An indirect service is always considered part of the encounter and is not reimbursed separately, even if provided on a different DOS or at a different location than the associated encounter.

CHCs and Tribal FQHCs identify encounters on claims by using HCPCS (Healthcare Common Procedure Coding System) procedure code T1015 (Clinic visit/encounter, all-inclusive) for services rendered.

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

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		U1 or U3 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), and Tribal FQHCs (POS codes 50 and XX), will not receive direct reimbursement for interpretive services as these are indirect services assumed to be already included in the bundled [PPS \(prospective payment system\)](#) (or [AIR \(all-inclusive rate\)](#) for Tribal FQHCs) rate. However, CHCs and Tribal FQHCs 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 Wisconsin DHS (Department of Health Services) to better track how CHCs and Tribal 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.

Providers are required to follow screening guidance from the USPSTF (United States Preventive Services Task Force) when ordering and performing low-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:

- ▮ 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 #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
- ┆ 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 (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 #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 interpreting 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:

- | 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 performed 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 #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 for encounters paid fee for service. This document does not apply to CHCs (community health centers) subject to [PPS \(prospective payment system\)](#) reimbursement or Tribal FQHCs subject to PPS or [AIR \(all-inclusive rate\)](#) reimbursement.

Services under the MTM (Medication Therapy Management) 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 these 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
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system

*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.

These 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, 93, or 95.

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, 93, or 95 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 (Healthcare Common Procedure Coding System) procedure code Q3014 (Telehealth originating site fee). Modifier GQ, GT, FQ, 93, or 95 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:

- ▮ Use 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 for encounters paid fee for service. This topic does not apply to Community Health Centers subject to [PPS \(prospective payment system\)](#) reimbursement or Tribal FQHCs subject to PPS or [AIR \(all-inclusive rate\)](#) 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, 93, or 95 will be considered under the PPS 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

These 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 99445, 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 and 99470 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, dietitian 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

The [Max Fee Schedules](#) include a complete list of services allowed under permanent telehealth policy. 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 a telehealth modifier in addition to any other required benefit-specific modifiers, unless the procedure code includes the method of delivery in the official procedure code description.

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.

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 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:

- | 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 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 Telemedicine 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
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	Nonphysician qualified health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
98971	Nonphysician qualified health care professional online digital assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11–20 minutes
98972	Nonphysician qualified health care professional online digital assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 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.

Telemedicine Evaluation and Management Services

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

Telemedicine Services Procedure Code	Description
98000	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
98001	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98002	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98003	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
98004	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
98005	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98006	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98007	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
98008	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

98009	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98010	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98011	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
98012	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.
98013	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98014	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98015	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
98016	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 evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion.

Managed Care

4

Archive Date:10/01/2026

Managed Care: Covered and Noncovered Services

Topic #16197

Care4Kids Program Benefit Package

Covered Services

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

Noncovered Services

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

- | 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
- | 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.

Topic #391

Noncovered Services

The following services are not covered by BadgerCare Plus HMOs or Medicaid SSI HMOs but are provided to members on a fee-for-service basis as long as ForwardHealth covers the service for the member, and the service is medically necessary:

- | [Behavioral treatment services](#) (for example, autism services)
- | Chiropractic services, unless the HMO elects to provide chiropractic services
- | County-based mental health programs, including CCS (comprehensive community services), CRS (Community Recovery Services), CSP (community support program) benefits, and crisis intervention services
- | Dental

Note: HMOs must provide dental services in Milwaukee, Waukesha, Racine, Kenosha, Ozaukee, and Washington counties.

- | Environmental lead investigation services provided through local health departments
- | Hub and Spoke Health Home or SUD (substance use disorder) pilot programs (integrated recovery support services)
- | Medication therapy management
- | Pharmacy services and diabetic supplies
- | PNCC (Prenatal care coordination) services
- | Physician-administered drugs

Note: The [Physician-Administered Drugs Carve-Out Procedure Codes table](#) indicates the status of procedure codes considered under the physician-administered drugs carve-out policy.

- | Residential SUD treatment
- | SBS (School-based services)
- | Targeted case management services
- | NEMT (Non-emergency medical transportation) services
- | DOT (Directly observed therapy) and monitoring for TB (tuberculosis)-Only Services

Providers who render any of these services to a BadgerCare Plus or Medicaid SSI HMO member should submit PA (prior authorization) requests and claims directly to ForwardHealth for coverage.

Enrollment

Topic #392

Disenrollment and Exemptions

In some situations, a member may be exempt from enrolling in a BadgerCare Plus HMO or Medicaid SSI HMO. Exempted members receive health care under fee-for-service. Exemptions allow members to complete a course of treatment with a provider who is not contracted with BadgerCare Plus HMO or SSI HMOs. For example, in certain circumstances, members seeing a specialist when they are enrolled in an HMO **may** qualify for an exemption if their specialty provider is not in the HMO networks.

The [contracts](#) between Wisconsin DHS (Department of Health Services) and the HMOs provide more detail on the exemption and disenrollment requirements.

Topic #393

Member Grievances

Members have the right to file a grievance with their HMO if they are unsatisfied with the services of the HMO or its providers. A member can file a grievance at any time for issues like:

- | Service quality.
- | Disrespect from a provider or an employee.
- | Violations of their member rights.

Members should contact the Wisconsin HMO [Ombudsman Program](#) to help solve the problem or write a formal grievance to the HMO. The SSI External Advocate can help SSI HMO members with filing a grievance.

Topic #399

Release of Billing or Medical Information

ForwardHealth supports BadgerCare Plus HMO and Medicaid SSI HMO enrollee rights regarding the confidentiality of health care records. ForwardHealth has [specific standards](#) regarding the release of an HMO or SSI HMO enrollee's billing information or medical claim records.

Managed Care Information

Topic #401

BadgerCare Plus HMO Program

An HMO is a system of health care providers that provides a comprehensive range of medical services to a group of enrollees. HMOs receive a fixed, prepaid amount per enrollee from ForwardHealth (called a capitation payment) to provide medically necessary services.

BadgerCare Plus HMOs are responsible for providing or arranging all contracted covered medically necessary services to enrollees. BadgerCare Plus members enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service members; however, HMOs may establish their own requirements regarding PA (prior authorization), claims submission, adjudication procedures, etc., which may differ from fee-for-service policies and procedures. BadgerCare Plus HMO network providers should contact their HMO for more information about its policies and procedures.

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

Topic #402

Managed Care Contracts

The contract between the Wisconsin DHS (Department of Health Services) and the BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) takes precedence over other ForwardHealth provider publications. Information contained in ForwardHealth publications is used by DHS to resolve disputes regarding covered benefits that cannot be handled internally by HMOs or PIHPs. If there is a conflict, the HMO or PIHP contract prevails. If the contract does not specifically address a situation, Wisconsin Administrative Code ultimately prevails. HMO and PIHP contracts are available on the [Acute and Primary Managed Care](#) page (click the HMO Providers link, then the Resources and Help tab) for HMOs and on the [Children's Specialty Programs](#) page of the ForwardHealth Portal (click the Children's Specialty Managed Care Plans link, then the Policy tab) for PIHPs.

Prior Authorization

Topic #400

Prior Authorization Procedures

BadgerCare Plus HMOs and Medicaid SSI HMOs may develop PA (prior authorization) guidelines that differ from fee-for-service guidelines. However, the application of such guidelines may not result in less coverage than fee-for-service. Contact the enrollee's HMO or SSI HMO for more information regarding PA procedures.

Provider Information

Topic #406

Copays

Providers cannot charge Medicaid SSI HMO enrollees copays for covered services except in cases where the Medicaid SSI HMO does not cover services such as dental, chiropractic, and pharmacy. However, even in these cases, providers are prohibited from collecting copay from members who are exempt from the copay requirement.

When services are provided through fee-for-service or to members enrolled in a BadgerCare Plus HMO, copays will apply, except when the member or the service is [exempt from the copay requirement](#).

Member Information

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Archive Date:10/01/2026

Member Information: Enrollment Categories

Topic #225

BadgerCare Plus

Populations Eligible for BadgerCare Plus

The following populations are eligible for BadgerCare Plus:

- ┆ Parents and caretakers with incomes at or below 100% of the FPL (Federal Poverty Level).
- ┆ Pregnant women with incomes at or below 300% of the FPL.
- ┆ Children (ages 18 and younger) with household incomes at or below 300% of the FPL.
- ┆ Childless adults with incomes at or below 100% of the FPL.
- ┆ Transitional medical assistance individuals, also known as members on extensions, with incomes over 100% of the FPL.

Where available, BadgerCare Plus members are enrolled in BadgerCare Plus HMOs. In those areas of Wisconsin where HMOs are not available, services will be reimbursed on a fee-for-service basis.

Premiums

The following members are required to pay premiums to be enrolled in BadgerCare Plus:

- ┆ Transitional medical assistance individuals with incomes over 133% of the FPL. Transitional medical assistance individuals with incomes between 100 and 133% FPL are exempt from premiums for the first six months of their eligibility period.
- ┆ Children (ages 18 and younger) with household incomes greater than 200% with the following exceptions:
 - ┆ Children under age 1 year.
 - ┆ Children who are tribal members or otherwise eligible to receive Indian Health Services.

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	BadgerCare Plus	0987654321
DOB: 09/01/1984		

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

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

Sample 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.

Enrollment Rights

Topic #247

Freedom of Choice

Members may receive covered services from **any** willing Medicaid-enrolled provider, unless they are enrolled in a state-contracted MCO (managed care organization) or assigned to the [Pharmacy Services Lock-In Program](#).

Special Enrollment Circumstances

Topic #23277

12-Month Continuous Health Care Coverage for Children

Most children enrolled in BadgerCare Plus or Medicaid programs will keep their health insurance coverage for 12 months. Even if their family has a change in income or other circumstances, children under age 19 will have coverage at least until their next renewal. This policy is required by the federal Consolidated Appropriations Act, 2023.

Children enrolled in Foster Care Medicaid or SSI Medicaid will have 12-months of continuous coverage even if their out-of-home placement, subsidized guardianship, court-ordered kinship care, adoption assistance agreement, or SSI payment ends.

Qualifying Programs

Members under age 19 in the following programs qualify for continuous coverage:

- | [BadgerCare Plus](#)
- | Emergency Services Medicaid
- | [Family Planning Only Services](#)
- | Foster Care Medicaid
- | HCBW (Home and Community-Based Waiver) Medicaid
- | Institutional Medicaid
- | Katie Beckett Medicaid
- | MAPP (Medicaid Purchase Plan)
- | Medicare Savings Programs
- | Special Status Medicaid
- | SSI (Supplemental Security Income)-Related Medicaid
- | SSI Medicaid
- | [Tuberculosis-Related Medicaid](#)
- | [Wisconsin Well Woman Medicaid](#)

Exceptions to Continuous Coverage

Continuous coverage does not apply to children:

- | Enrolled under presumptive eligibility, also known as [Express Enrollment](#).
- | Enrolled by meeting a deductible. These are members who become eligible for up to a six-month period based on their medical expenses.

Children remain eligible for the 12 months until their next renewal unless:

- | They turn 19.
- | They move out of Wisconsin.
- | Their citizenship or immigration status is not verified.
- | Their eligibility was based on inaccurate information or agency error.
- | The family asks to end their coverage.

Assisting Members Through Enrollment Renewals

Helping families through the health care renewal process remains vital to keeping children covered. Providers are asked to remind BadgerCare Plus and other Wisconsin Medicaid program members to renew their coverage, even if they think their situation will change in the future. Members should also be reminded to tell their agency about any changes to their address, phone number, or email to ensure they continue to receive important information about their health care coverage from Wisconsin DHS (Department of Health Services).

Member Resources

Free Health Insurance Application and Renewal Assistance

Members who need help with applying for or renewing health care coverage can access the following resources:

- ▮ Covering Wisconsin (free expert help with health insurance), available at the [WisCovered](#) website
- ▮ [211 Wisconsin](#) at 211 or 877-947-2211

Continuous Coverage and Health Care Renewal Information

Additional member resources regarding health care renewals and continuous coverage for children are available:

- ▮ [Medicaid: Programs for Children](#) web page
- ▮ [Health Care Renewals](#) web page
- ▮ "Keeping Kids Covered" [12-Month Continuous Coverage for Children fact sheet](#)
- ▮ [BadgerCare Plus: Frequently Asked Questions](#)

Additional policy information on continuous coverage for children is [available](#) in the BadgerCare Plus Handbook.

Prior Authorization

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Archive Date:10/01/2026

Prior Authorization:Advanced Imaging Services

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 (for example, radiology clinics). [eviCore healthcare](#), a private radiology benefits manager, is authorized to administer PA for advanced imaging services on behalf of ForwardHealth. Additional information about PA requirements and submission information for advanced imaging services [is available](#).

Services Requiring Prior Authorization

Topic #19817

Personal Continuous Glucose Monitoring Devices and Supplies

ForwardHealth covers personal [continuous glucose monitors and supplies](#) in accordance with guidance from the American Diabetes Association and American Association of Clinical Endocrinology for diabetic members who are on insulin, need to check their blood sugar frequently, or are at risk for hypoglycemia. Adults and children, including infants and toddlers, may use a personal continuous glucose monitoring device and supplies to estimate blood glucose levels automatically, which will allow levels to be reviewed and tracked closely.

Coverage Criteria

Personal continuous glucose monitors and supplies are covered for members who meet all of these criteria:

- | The member has a diagnosis of any type of diabetes, excluding pre-diabetes.
- | The member or the member's caregiver has the cognitive ability to be educated about the device, the willingness to use the device, and the physical capability to use the device.
- | The member has a written prescription dated within the last 12 months from a qualified health care professional on the member's medical team, including the name of the continuous glucose monitor prescribed.
- | The prescribed continuous glucose monitor is appropriate for the member's age.

Continuous glucose monitors and supplies are covered under ForwardHealth's DME (durable medical equipment) benefit.

Required Documentation

This documentation for fee-for-service claims must be kept in the member's medical record, dated within the last 12 months and must be produced upon the request of Wisconsin DHS (Department of Health Services):

- | Documentation of the member's diabetes diagnosis
- | A written prescription from a licensed, qualified health care professional on the member's medical team
- | A qualified health care professional-ordered diabetic treatment plan
- | The name of the prescribed glucose monitoring device
- | Documentation that the member or the member's caregiver has the cognitive ability to be educated about the device, the willingness to use the device, and the physical capability to use the device

Prior Authorization

PA (Prior authorization) is required:

- | For out-of-state, non-border-status providers.
- | For prescription of a backup device.
- | If a new device is required within three years of having had one dispensed. (Note: Continuous glucose monitors have an expected life of three years, and members can receive one every three years without PA.)

When a PA is needed, this information must be submitted:

- | A completed [PA/RF \(Prior Authorization Request Form, F-11018 \(04/2026\)\)](#)
- | A completed [PA/DMEA \(Prior Authorization/Durable Medical Equipment Attachment, F-11030 \(02/2024\)\)](#)
- | Documentation of the member's diabetes diagnosis
- | A written prescription dated within the last 12 months, including the name of the continuous glucose monitor prescribed, from a licensed qualified health care professional on the member's medical team
- | A qualified health care professional-ordered diabetic treatment plan
- | The name of the prescribed glucose monitoring device
- | Documentation that the member or the member's caregiver has the cognitive ability to be educated about the device, the willingness to use the device, and the physical capability to use the device

HMOs have the option to require PA for these devices.

Provider Enrollment and Ongoing Responsibilities

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Archive Date:10/01/2026

Provider Enrollment and Ongoing Responsibilities:Documentation

Topic #6277

1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than \$600, 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

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\(9\)\(e\)](#). 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).

If Wisconsin Medicaid requires a provider to submit hard copies of records instead of scanning or accepting electronic records during a compliance audit, DHS reimburses providers \$0.06 per page. A letter of request for records from DHS will be sent to a provider when records are required, with instructions on how to submit records electronically or if physical records are required.

Reimbursement is not made for other reproduction costs included in the provider agreement between 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 DHS.

The reproduction of records requested by the PRO (Peer Review Organization) under contract with 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 (for example, 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](https://nvlap.nist.gov/special-publications/800-88/).

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% of the applicable fees for providing one set of copies of the member's health care records.

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

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. Stat. § [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 (for example, 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. 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 C.F.R. 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 C.F.R. 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 C.F.R. 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 C.F.R. 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

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 (for example, 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 DHS, as well as to provide copies of the corresponding patient health care records.

Ongoing Responsibilities

Topic #220

Accommodating Members With Disabilities

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

Topic #219

Civil Rights Compliance (Nondiscrimination)

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

- ▮ 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

These 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% 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 fewer 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 can get 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
201 E Washington Ave Room B300
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 (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 (for example, 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 (for example, 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 (for example, 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 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 (for example, 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 (for example, 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 (for example, 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 HDAP (Wisconsin HIV 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 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 their 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.

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 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.

PA for Weight Management Agents

Prescribers, or their designees, must request PA for [weight management agents](#); pharmacy providers may not request PA for weight management agents.

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 \(01/2024\)\)](#) 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 \(02/2025\)\)](#) 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 (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 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 C.F.R. Part 493, Laboratory Requirements

Scope of CLIA

CLIA governs all laboratory operations, including:

- | 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:

- | Clinics
- | HealthCheck providers
- | Independent clinical laboratories
- | Nurse midwives
- | Nurse practitioners

- | Osteopaths
- | Pharmacists
- | Physician assistants
- | Physicians
- | Rural health clinics

CLIA Certification Types

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 enables a laboratory to conduct moderate- or high-complexity laboratory testing, or both, until the lab 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 certificate is issued to a laboratory on the basis of the laboratory's accreditation by an organization approved by CMS. The six major approved accreditation organizations are:
 - | The Joint Commission
 - | CAP (College of American Pathologists)
 - | COLA (Commission on Laboratory Accreditation)
 - | 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 can get CMS 116 forms from the [CMS website](#) or from Wisconsin DHS (Department of Health Services) at:

Division of Quality Assurance
 Clinical Laboratory Section
 201 E Washington Ave
 PO Box 2969
 Madison WI 53701-2969

Providers Required to Report Changes

Providers are required to notify Provider Enrollment within 30 days of any changes in ownership, name, location, or director. Providers are also required to notify Provider Enrollment of changes in CLIA certificate types immediately and within six months when a specialty or 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:

Wisconsin Medicaid
 Provider Enrollment
 313 Blettner Blvd
 Madison WI 53784

If a provider has a new certificate type to add to the 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:

- ┆ Billing and 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 and Rendering Provider

Enrollment as a billing and 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

A provider enrolled as a rendering-only provider who practices under the professional supervision of another provider. Rendering-only providers enrollment cannot submit claims to ForwardHealth directly. Instead, 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)

Billing-only providers can submit claims to ForwardHealth while a separate rendering-only provider is required on those 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 worked toward ACA compliance by implementing [requirements for providers and provider screening processes](#). To meet federally mandated requirements, ForwardHealth implemented 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 & 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, re-enrollment, 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](#) and other providers who receive Medicaid funds 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 HDAP (Wisconsin HIV 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 must notify ForwardHealth of a change in ownership within 35 calendar days after the effective date of the change per CMS (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.

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

New Enrollment Application Is Required

Any time a change in ownership occurs, providers must complete a new [Medicaid provider enrollment application](#) on the Portal. Indicate that this is a change of ownership on the application.

ForwardHealth must receive the change in ownership application, 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

These 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)

Additional Requirements for Providers Required to Use EVV

Providers required to use EVV when rendering [certain services](#) can ensure a successful transition by:

- | Reviewing the [EVV and Provider Agency Change of Ownership document, P-03819](#).
- | Contacting Wisconsin EVV Customer Care at vdxc.contactevv@wisconsin.gov or 833-931-2035 Monday–Friday, 7 a.m.–6 p.m. Central Time.

Events 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.

These 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
 - | LLCs (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:

- | 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 must repay ForwardHealth for any incorrect payments or overpayments made to them. The new owner's application will be denied if the previous owner does not repay ForwardHealth for any incorrect payments or overpayments.

If necessary, ForwardHealth will hold the provider who receives the transfer of ownership before the final transfer of ownership responsible for repayment. The provider acquiring the business is responsible for contacting ForwardHealth to find out if they are liable under this provision.

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

Providers may send inquiries about determining of any pending liability:

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.

Providers Must Submit New Prior Authorization Requests After a Change in Ownership

Medicaid-enrolled providers must submit new PA (prior authorization) requests when there is a change in billing providers. Providers must submit new PA requests with the new billing provider's name and billing provider number. The expiration date of the new PA request will stay the same as the original PA request.

The provider must send this information 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 end date the original PA request (may be a photocopy), which should include:
 - ┆ 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–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–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

ForwardHealth adopted terminology due to the ACA (Affordable Care Act), which is included in the following table. This terminology is 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.

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 5% or more in a disclosing entity ┆ Has an indirect ownership interest equal to 5% or more in a disclosing entity ┆ Has a combination of direct and indirect ownership interest equal to 5% or more in a disclosing entity ┆ Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% 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 revalidates 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.

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 for encounters paid fee-for-service. This topic does not apply to CHCs (community health centers) subject to [PPS \(prospective payment system\)](#) reimbursement or Tribal FQHCs subject to PPS or [AIR \(all-inclusive rate\)](#) 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 for encounters paid fee-for-service. This document does not apply to CHCs (community health centers) subject to [PPS \(prospective payment system\)](#) reimbursement or Tribal FQHCs subject to PPS or [AIR \(all-inclusive rate\)](#) 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](#).

Provider Rights

Topic #208

A Comprehensive Overview of Provider Rights

Medicaid-enrolled providers have certain rights including:

- | 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 (for example, 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. [DHS 227](#), may request a hearing by writing to the DHA (Division of Hearings and Appeals).

A provider who wishes to contest DMS (Division of Medicaid Services)'s notice of intent to recover payment (for example, 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 DHS's 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 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 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.

DMS may also require additional information from the provider or the member prior to acting on the request.

Application

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, 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\(3\)](#), 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 DHA (Division of Hearings and Appeals).

Topic #212

Involuntary Termination

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

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.

Reimbursement

8

Archive Date:10/01/2026

Reimbursement:Amounts

Topic #258

Acceptance of Payment

The amounts allowed as payment for covered services must be accepted as payment in full. Therefore, total payment for the service (for example, any amount paid by other health insurance sources, any BadgerCare Plus or Medicaid copay or spenddown amounts paid by the member, and any amount paid by BadgerCare Plus, Medicaid, or HDAP (Wisconsin HIV Drug Assistance Program)) may not exceed the allowed amount. As a result, providers may not collect payment from a member or authorized person acting on behalf of the member, for the difference between their usual and customary charge and the allowed amount for a service (for example, balance billing).

Other health insurance payments may exceed the allowed amount if no additional payment is received from the member or BadgerCare Plus, Medicaid, or HDAP.

Topic #24123

All-Inclusive Rate Reimbursement

Wisconsin Tribal FQHCs (federally qualified health centers) receive reimbursement for Medicaid-covered services through one of two options:

- ▮ [PPS \(prospective payment system\)](#)—ForwardHealth establishes a prospective encounter rate for each Tribal FQHC that reflects their estimated reasonable costs of providing care in accordance with the Benefits Improvement and Protection Act of 2000.
- ▮ AIR (all-inclusive rate)—IHS (Indian Health Services) calculates and publishes all-inclusive reimbursement rates each year in the [Federal Register](#). The rates are based on annual cost reports prepared by IHS's contractor.

ForwardHealth uses these reimbursement rates through the authority of the approved [Wisconsin State Plan Amendment 24-0008](#). The [Medicaid State Plan Attachment 4.19-B](#) has:

- ▮ Pharmacy information on page 5a.
- ▮ AIR information on pages 10.d.–10.h.

ForwardHealth does not reimburse Tribal FQHCs under the cost-settlement process for services rendered on and after January 1, 2024.

Rates and Reimbursement

Under AIR, ForwardHealth reimburses Tribal FQHCs for an encounter rate which includes all direct and indirect services provided to a member during an encounter.

ForwardHealth will apply the PPS rate or AIR for the encounter type to a claim detail associated with HCPCS (Healthcare Common Procedure Coding System) procedure code T1015. All other payable claim details for direct and indirect services on the claim associated with the encounter will process in a paid status with a \$0 allowed amount.

ForwardHealth only reimburses Tribal FQHCs for covered services and does not reimburse providers for the cost of any Tribal

FQHC activities and services that:

- ┆ Are not required by ForwardHealth.
- ┆ Are part of Tribal FQHC-related services included in state statute or administrative code.

Calculation of the All-Inclusive Rate

A Tribal FQHC's AIR will be reimbursed per the rate published annually in the Federal Register.

Choosing a Reimbursement Rate

The Tribal FQHC can choose between the PPS or AIR as their preferred reimbursement rate at the start of each calendar year using this information:

1. CMS (Centers for Medicare & Medicaid Services) will publish the market basket data and update the Federal Register for the upcoming year.
2. Wisconsin DHS (Department of Health Services) will send a letter to the Tribal FQHC detailing the new rates for both PPS and AIR. DHS intends for Tribal FQHCs to receive these letters in December each year.
3. Tribal FQHCs must inform DHS of their chosen rate for the upcoming year within the timeline specified in the letter.

If a Tribal FQHC chooses their rate after January 1, non-pharmacy claims dating back to January 1 will be automatically adjusted to their chosen rate.

If the Tribal FQHC does not send a decision to DHS within the timeline detailed in the letter, DHS will apply the method the Tribal FQHC chose the previous year with the updated rates.

Billing Procedure Code

The Tribal FQHC PPS or AIR implementation date is the date when a Tribal FQHC became eligible for billing HCPCS procedure code T1015 (Clinic visit/encounter, all inclusive) for eligible claims. **Billing providers must include HCPCS code T1015 on the claim along with a dental, mental health, or medical covered service code to receive their PPS rate or AIR for qualified encounters.**

Tribal FQHCs may email the Wisconsin DHS Tribal FQHC inbox at DHSTRIBALFQHC@dhs.wisconsin.gov to find out when they can start submitting claims with HCPCS code T1015.

Topic #24124

Dental Services

For the purposes of this Online Handbook topic:

- ┆ A [PPS \(prospective payment system\)](#) rate applies to CHCs (community health centers) and Tribal FQHCs (federally qualified health centers).
- ┆ An [AIR \(all-inclusive rate\)](#) applies to Tribal FQHCs only.

ForwardHealth will reimburse CHCs and Tribal FQHCs an encounter rate for each allowed dental visit. A dental visit qualifies for PPS or AIR by meeting all defined program requirements:

- ┆ The rendering provider must be enrolled with Wisconsin Medicaid.
- ┆ The services provided must qualify as [direct services](#).

- The services provided must be [covered procedure codes](#).

ForwardHealth reimburses Tribal FQHCs for dental services requiring [multiple visits](#) when:

- The provider bills the procedure code, or base code, that represents the final prosthesis or dental service.
- Each additional visit that occurs before completing the final procedure is represented on the claim by an associated code.

Note: Not every base code requires an associated procedure code.

Wisconsin DHS (Department of Health Services) requires a compliance review of each associated procedure code service when a base procedure code is not rendered or is denied (such as when the base procedure code does not meet program requirements for reimbursement). Provider reimbursement for the associated codes depends on [DHS review](#).

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 who 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 RA (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 (for example, a decimal point is omitted creating a \$50,000 keyed value for a \$500 claim), a reversal will take place to correct the error and resend the correct transaction value. ForwardHealth will notify the designated EFT contact person of an EFT reversal if a payment is made in error due to a system processing or manual data entry error.

Problem Resolution

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

Topic #22058

Prospective Payment System Reimbursement

For the purposes of this Online Handbook topic:

- ▮ A [PPS \(prospective payment system\)](#) rate applies to CHCs (community health centers) and Tribal FQHCs (federally qualified health centers).
- ▮ An [AIR \(all-inclusive rate\)](#) applies to Tribal FQHCs only.

Rates and Reimbursement

Under PPS, ForwardHealth reimburses CHCs and Tribal FQHCs for an encounter rate which includes all direct and indirect services provided to a member during an encounter.

ForwardHealth will apply the PPS rate or AIR for the encounter type to a claim detail associated with HCPCS (Healthcare Common Procedure Coding System) procedure code T1015. All other payable claim details for direct and indirect services on the claim associated with the encounter will process in a paid status with a \$0 allowed amount.

ForwardHealth only reimburses Tribal FQHCs for covered services and does not reimburse providers for the cost of any Tribal FQHC activities and services that:

- ▮ Are not required by ForwardHealth.
- ▮ Are part of Tribal FQHC-related services included in state statute or administrative code.

Calculation of the Prospective Payment System Rate

ForwardHealth calculates a separate PPS rate for each CHC or Tribal FQHC per the Benefits Improvement and Protection Act of 2000.

At the end of each CHC or Tribal FQHC fiscal year, ForwardHealth adjusts the PPS rate using FQHC market basket in effect at the time, which replaced the MEI (Medicare Economic Index) in 2017. In addition, ForwardHealth may adjust a CHC's or Tribal FQHC's PPS rate to account for changes in the CHC's or Tribal FQHC's scope of service.

Reimbursement Guidelines

ForwardHealth reimburses a CHC or Tribal FQHC a maximum of one PPS rate per encounter type, per member, per DOS (date of service) **unless** the member suffers an illness or injury **after the first encounter** that requires additional diagnosis or treatment on the same day.

When a CHC or Tribal FQHC member receives services of the same encounter type in a single day at more than one CHC or Tribal FQHC location (for example, the main clinic, an off-site clinic, and/or a contracted facility), ForwardHealth will reimburse the CHC or Tribal FQHC for only one encounter type per DOS—unless the additional encounter qualifies as a subsequent encounter.

Reimbursement for Services Provided by a Pharmacist

If the billing provider is a CHC or Tribal FQHC and the rendering provider is the pharmacist, then the CHC or Tribal FQHC may bill for covered medical services provided by the CHC's or Tribal FQHC's pharmacist. However, because the pharmacist is providing medical services, the one payer per service per day rule still applies. Encounter counting logic for PPS rates applies when all conditions are met for qualified encounters.

Services "Carved-Out" of the PPS Rate

Physician-administered drugs, telehealth distant site services, and certain pharmacy services are "carved out" of (not included in) PPS and are reimbursed separately.

Pharmacy Services

Some CHCs and Tribal FQHCs provide pharmacy services and bill for them on a ForwardHealth compound or noncompound drug claim. A CHC or Tribal FQHC pharmacy provider must enroll as a separate Medicaid provider under the applicable pharmacy provider type and specialty. The pharmacy must have the same tax ID as the main service location of the associated CHC or Tribal FQHC.

If a Tribal FQHC adds pharmacy services to their practice, they may qualify for a change in scope that may increase their PPS rate.

Physician-Administered Drugs

Physician-administered drugs are drugs administered by a provider in an office setting. The [Physician-Administered Drugs Resources](#) page contains a list of procedure codes classified as physician-administered drugs that may be reimbursed in addition to the PPS rate for an encounter. These services are subject to change and must meet all applicable ForwardHealth program requirements, including medical necessity, PA (prior authorization), claims submission, prescription requirements, and documentation requirements.

Telehealth Services

[Telehealth services](#) include "originating site" services and/or "distant site" services.

- ┆ Originating site services are not eligible for PPS.
- ┆ Distance site services are counted as encounters and must meet PPS rates guidelines.

CHC or Tribal FQHC costs associated with telehealth or teledentistry services may be reported for change in scope adjustment consideration; therefore, telehealth and teledentistry service costs may be used for future rate setting purposes.

Topic #23338

Tribal Federally Qualified Health Center Encounter Reimbursement

For the purposes of this Online Handbook topic, FQHC (federally qualified health center) refers to Tribal and out-of-state FQHCs for encounters paid through the cost settlement process. This document does not apply to Tribal FQHCs subject to [PPS \(prospective payment system\)](#) or [AIR \(all-inclusive rate\)](#) reimbursement for services.

FQHCs can generally receive payment for one encounter per day, per member for covered services each for medical, dental, and mental health services.

Multiple contacts with the same health professional that take place on the same day at a single location for treatment of the same health condition or diagnosis constitutes a single encounter **unless** the member suffers illness or injury that requires additional diagnosis or treatment **after** the first encounter.

If a member visits a physician and a dentist on a single day, those visits will be classified as two encounters. However, if a member visits a physician and a [pharmacist](#) on a single day, those visits will be classified as a single encounter.

If the billing provider is the FQHC itself and the rendering provider is the pharmacist, an FQHC may bill for covered medical services provided by the FQHC's pharmacist. However, because the pharmacist is providing medical services, the one payer per service per day rule still applies. When all conditions are met, the PPS rate would apply.

If an FQHC adds pharmacy services to their practice, they may qualify for a change in scope that may increase their PPS rate.

Topic #24003

Tribal Shared Savings

Tribal shared savings applies to billable Medicaid services provided to Native American or Alaskan tribal members referred to providers outside of tribal facilities by Tribal FQHCs (Federally Qualified Health Centers).

Outside Provider Claims

Outside provider claims are now eligible for 100% [FMAP \(Federal Medical Assistance Percentage\)](#) if the provider has a signed care coordination agreement with the relevant Tribal FQHC.

Previously, when tribal members received services from outside providers, those claims were only eligible for standard FMAP.

100% FMAP Claim Eligibility

To make sure a claim qualifies for 100% FMAP, Tribal organization services must be:

- | Provided to a Medicaid-eligible Native American or Alaskan Native.
- | Authorized according to Indian Health Service rules (including long-term services).
- | Performed by a contractual agent through a signed care coordination agreement.

The partnering provider must submit the referred claim by including the Tribal FQHC's NPI (National Provider Identifier) or Medicaid Provider ID in the Referring Provider or Referral Number fields.

The Tribal Facility practitioner remains responsible for overseeing their patients' care and the Tribal Facility remains in control of their patients' medical records.

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 for encounters paid through the cost settlement process. This document does not apply to CHCs (community health centers) subject to [PPS \(prospective payment system\)](#) reimbursement or Tribal FQHCs subject to PPS or [AIR \(all-inclusive rate\)](#) 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 (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 #22017

Cost Report Form

CHCs (Community health centers) and Tribal FQHCs (federally qualified health centers) are required to use the [Federally Qualified Health Center Cost Report \(F-02656 \(01/2021\)\)](#) for cost settlements.

The Federally Qualified Health Center cost report is available to providers in a single, fillable Microsoft Excel workbook. After opening the workbook, providers may click the navigation buttons in 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 #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 for encounters paid through the cost settlement process. This document does not apply to CHCs (community health centers) subject to [PPS \(prospective payment system\)](#) reimbursement or Tribal FQHCs subject to PPS or [AIR \(all-inclusive rate\)](#) 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 #22018

Outstationed Enrollment

Following the end of a CHC (community health center)'s or Tribal FQHC's (federally qualified health center's) fiscal year, the CHC or Tribal FQHC must complete a [Federally Qualified Health Center Outstationed Enrollment Survey \(F-02758 \(01/2021\)\)](#) form:

- ▮ CHCs should send the completed form to DHSWIFQHC@dhs.wisconsin.gov.
- ▮ Tribal FQHCs should send the completed form to DHSTRIBALFQHC@dhs.wisconsin.gov.

The CHC or Tribal FQHC has 120 days to fill out this form after the end of their fiscal year.

ForwardHealth will review reported outstationed enrollment expenditures and calculate the difference between the known portions of the [PPS \(prospective payment system\)](#) rate that is outstationed enrollment and the actual outstationed enrollment cost incurred during the fiscal year.

Through the reconciliation process, Medicaid payments associated with outstationed enrollment will equal 100% of the CHC or Tribal FQHC allowable outstationed enrollment expenditures.

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 for encounters paid through the cost settlement process. This document does not apply to CHCs (community health centers) subject to [PPS \(prospective payment system\)](#) reimbursement or Tribal FQHCs subject to PPS or [AIR \(all-inclusive rate\)](#) reimbursement.

Following the end of the FQHC's fiscal year, the FQHC will complete and submit to OIG (Office of Inspector General) 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 outstationed enrollment will equal 100% 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 for encounters paid fee for service. This document does not apply to CHCs (community health centers) subject to [PPS \(prospective payment system\)](#) reimbursement or Tribal FQHCs subject to PPS or [AIR \(all-inclusive rate\)](#) 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 for encounters paid fee for service. This document does not apply to Community Health Centers subject to [PPS \(prospective payment system\)](#) reimbursement or Tribal FQHCs subject to PPS or [AIR \(all-inclusive rate\)](#) 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 (for example, cost settlements) that equal 100% 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.

Topic #1637

Tribal Federally Qualified Health Center Interim Report Form

For the purposes of this Online Handbook topic, FQHC (federally qualified health center) refers to Tribal FQHCs.

Tribal FQHCs receiving [PPS \(prospective payment system\)](#) or [AIR \(all-inclusive rate\)](#) reimbursement may self-report encounters when PPS and AIR are excluded from T1015 payment by completing supplemental interim reports, also known as wrap reports. The report details estimated eligible encounters that are not reimbursed using PPS or AIR, such as HMO claims or fee-for-service Medicare Crossover claims. Tribal FQHCs can use the interim form as a cash flow option to be paid for the difference between the max fee paid via the claims engine and the PPS rates or AIR. The payment amount is estimated until it is officially reconciled to pull actual encounters and revenue.

Wisconsin DHS (Department of Health Services) checks claims for reasonability and issues payment based on the requested amount on the form. Supplemental interim forms are risk-based and later reconciled against actual encounters using an encounter reconciliation process. An encounter reconciliation results in either a payment, recoupment, or no action. No action occurs when self-reported encounters from the interim forms fall within 5% variance of actual encounters. Payment or recoupment occurs when self-reported encounters on interim forms falls outside the 5% variance of actual encounters by either over-reporting or under-reporting.

Submission Frequency

Interim forms should be submitted no less than quarterly but may be submitted monthly.

Supplement Interim Report Form

Tribal FQHCs may use the Tribal Federally Qualified Health Center Interim Report form to report non-PPS rate or AIR payment and request the difference up to their PPS rate or AIR.

Tribal FQHCs may request Supplemental Interim Report Forms for their Tribal FQHC and submit completed forms by emailing DHS Tribal FQHC at DHSTRIBALFQHC@dhs.wisconsin.gov.

Payer of Last Resort

Topic #242

Instances When Medicaid is Not Payer of Last Resort

Wisconsin Medicaid or BadgerCare Plus are **not** the payer of last resort for members who receive coverage from certain governmental programs, such as:

- ┆ Birth to 3
- ┆ Crime Victim Compensation Fund
- ┆ GA (General Assistance)
- ┆ HCBS (Home and Community-Based Services) waiver programs:
 - ┆ CLTS (Children's Long-Term Support Program)
 - ┆ Family Care
 - ┆ Family Care Partnership
 - ┆ IRIS (Include, Respect, I Self-Direct)
- ┆ IDEA (Individuals with Disabilities Education Act)
- ┆ Indian Health Service
- ┆ Maternal and Child Health Services
- ┆ WCDP (Wisconsin Chronic Disease Program):
 - ┆ Adult Cystic Fibrosis
 - ┆ Chronic Renal Disease
 - ┆ Hemophilia Home Care

Providers should ask members if they have coverage from these other governmental programs.

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

Reimbursement Not Available

Topic #1033

Reimbursement Not Available

Wisconsin Medicaid may deny or recoup payment for covered services that fail to meet program requirements. Medicaid reimbursement is also not available for noncovered services.

The following are not reimbursable as ambulance services:

- | Additional charges to pick up a member's personal belongings
- | Ambulance trips to obtain physical, occupational or speech therapy, audiology, chiropractic, or psychotherapy services
- | Charges for a member's failure to cancel a scheduled transport
- | Excessive mileage
- | Extra charges for nights, weekends, or holiday services
- | Medical personnel who care for the member in transit (other than those employed by the ambulance provider)
- | No member conveyance
- | Processes, treatments, or services which are an integral part of care while in transit (for example, complex bandaging procedures, ECG monitoring, drugs used in transit or for starting intravenous solutions)
- | Reusable devices and equipment such backboards, neckboards, and inflatable splints
- | Sales tax
- | Specialty care transport in combination with other ambulance service base rates
- | Transportation of lab specimens
- | Trips for the purpose of locating a member closer to their family or home
- | Trips to relocate a member for the sole purpose of improving the member's mental, psychological, or emotional health
- | Trips to facilities where no medical services are received (for example, a daycare center or sheltered workshop)
- | Vehicle sterilization

Resources

9

Archive Date:10/01/2026

Resources:Contact Information

Topic #476

Member Services

Providers should refer ForwardHealth members with questions to [Member Services](#). The telephone number for Member Services is for member use only.

Topic #473

Professional Field Representatives

Professional field representatives, also known as field representatives, are available to assist providers with complex billing and claims processing questions. Field representatives are located throughout the state to offer detailed assistance to all ForwardHealth providers and all ForwardHealth programs.

The field representatives are assigned to [specific regions](#) of the state. Most professional field representatives can address inquiries for all provider types. However, certain dedicated professional field representatives are assigned to the following:

- | Adult long-term care
- | Dental providers
- | Milwaukee County
- | PNCC (Prenatal care coordination) and CCC (child care coordination)
- | WWP (Wisconsin Well Woman Program)

Provider Education

The field representatives' primary focus is provider education. They provide information on ForwardHealth programs and topics in the following ways:

- | Conducting provider training sessions throughout the state
- | Providing training and information for newly enrolled providers and/or new staff
- | Participating in professional association meetings

Providers may also contact the field representatives if there is a specific topic, or topics, on which they would like to have an individualized training session. This could include topics such as use of the ForwardHealth Portal (information about claims, enrollment verification, and PA (prior authorization) requests on the Portal). Refer to the [Providers Trainings page](#) for the latest information on training opportunities.

Additional Inquiries

Providers are encouraged to initially obtain information through the Portal, WiCall, and Provider Services. If these attempts are not successful, field representatives may be contacted for the following types of inquiries:

- | Claims, including discrepancies regarding enrollment verification and claim processing
- | PES (Provider Electronic Solutions) claims submission software
- | Claims processing problems that have not been resolved through other channels (for example, phone or written)

correspondence)

- ┆ Referrals by a Provider Services phone correspondent
- ┆ Complex issues that require extensive explanation

At times, professional field representatives work outside their offices to provide on-site service; therefore, providers should be prepared to leave a complete message when contacting field representatives, including all pertinent information related to the inquiry. Member inquiries should not be directed to field representatives. Providers should refer members to [Member Services](#).

If contacting a field representative by email, providers should ensure that no individually identifiable health information, known as PHI (protected health information), is included in the message. Discuss the appropriate method of sending emails with your assigned field representative to ensure secure transmission of information.

Providers or their representatives should have the following information ready when they contact their professional field representative:

- ┆ Name or alternate contact
- ┆ County and city where services are provided
- ┆ Name of facility or provider whom they are representing
- ┆ NPI (National Provider Identifier) or provider number
- ┆ Phone number, including area code
- ┆ A concise statement outlining concern
- ┆ Days and times when available

For questions about a specific claim, providers should also include the following information:

- ┆ Claim number
- ┆ DOS (date of service)

Topic #474

Provider Services

Providers should call [Provider Services](#) to answer enrollment, policy, and billing questions. Members should call [Member Services](#) for information. Members should **not** be referred to Provider Services.

The Provider Services Call Center provides service-specific assistance to Medicaid, BadgerCare Plus, WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program) providers.

Ways Provider Services Can Help

The Provider Services Call Center is organized to include program-specific and service-specific assistance to providers. The Provider Services Call Center supplements the ForwardHealth Portal and WiCall by providing information on the following:

- ┆ Billing and claim submission
- ┆ Provider enrollment
- ┆ Member enrollment
- ┆ COB (coordination of benefits) (for example, verifying a member's other health insurance coverage)
- ┆ Assistance with completing forms
- ┆ Assistance with remittance information and claim denials
- ┆ Policy clarification
- ┆ PA (prior authorization) status
- ┆ Claim status

- ▮ Verifying covered services

Information to Have Ready

When contacting or transferring from WiCall to the call center, callers will be prompted to enter their NPI (National Provider Identifier) or provider ID. Additionally, to facilitate service, providers are recommended to have all pertinent information related to their inquiry on hand when contacting the call center, including:

- ▮ Provider name and NPI or provider ID
- ▮ Member name and ID
- ▮ Claim ICN (internal control number)
- ▮ PA number
- ▮ DOS (date of service)
- ▮ Amount billed
- ▮ RA (Remittance Advice)
- ▮ Procedure code of the service in question
- ▮ Reference to any provider publications that address the inquiry

Call Center Representatives

The ForwardHealth call center representatives are organized to respond to phone calls from providers. Representatives offer assistance and answer inquiries specific to the program (for example, Medicaid, WCDP, or WWWP) or to the service area (for example, pharmacy services, hospital services) in which they are designated.

In addition to trained call center representatives, Provider Services employs an automated tool for assisting callers. The virtual agent is available 24 hours a day, seven days a week to answer questions that do not require a call center representative, such as inquiries related to:

- ▮ Claim status
- ▮ PA status
- ▮ Provider payment status
- ▮ Member enrollment verification

Walk-in Appointments

Walk-in appointments offer face-to-face assistance for providers at the Provider Services office. Providers must schedule an appointment in advance by contacting Provider Services at 800-947-9627. Appointments for in-person provider assistance are available Monday through Friday, 7:30 a.m. – 4 p.m. (Central time), except for state-observed holidays. Providers without an appointment may not receive in-person assistance and may have to schedule an appointment for a later date.

Written Inquiries

Providers may contact Provider Services through the Portal by selecting the Contact Us link. Provider Services will respond to the inquiry by the preferred method of response indicated within five business days. All information is transmitted via a secure connection to protect personal health information.

Providers may submit written inquiries to ForwardHealth by mail using the [Written Correspondence Inquiry \(F-01170 \(07/2012\)\)](#) form. The Written Correspondence Inquiry form may be photocopied or downloaded via a link from the Portal. Written correspondence should be sent to the following address:

ForwardHealth

Provider Services Written Correspondence
313 Blettner Blvd
Madison WI 53784

Providers are encouraged to use the other resources before mailing a written request to ForwardHealth. Provider Services will respond to written inquiries in writing unless otherwise specified.

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 – Friday, 7 a.m. – 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 - Family Care - Family Care Partnership - IRIS (Include, Respect, I Self-Direct) - PACE (Program of All-Inclusive Care for the Elderly) - HDAP (Wisconsin HIV 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 – Friday, 8:30 a.m. – 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 – Friday, 8:30 a.m. – 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 – Friday, 7 a.m. – 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 – Friday, 7 a.m. – 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 – Friday, 8 a.m. – 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 HIV Drug Assistance Program	800-991-5532	Monday – Friday, 8 a.m. – 4:30 p.m. (Central time)*
To assist HDAP providers and members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		

*With the exception of state-observed holidays.

Electronic Data Interchange

Topic #461

Electronic Data Interchange Helpdesk

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

Providers with policy questions should call [Provider Services](#).

Enrollment Verification

Topic #469

An Overview

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

- ▮ A member's enrollment in a ForwardHealth program(s)
- ▮ State-contracted MCO (managed care organization) enrollment
- ▮ Medicare enrollment
- ▮ Limited benefits categories
- ▮ Any other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) coverage
- ▮ Exemption from copays 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 inquiries, a From DOS is the earliest date for which the provider is requesting enrollment information and the To DOS is the latest date for which the provider is requesting enrollment information.

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

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

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

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

Topic #4899

Member Identification Card Does Not Guarantee Enrollment

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

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 (for example, 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 (for example, 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 (for example, 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 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 SeniorCare.)
- ┆ SSI (Supplemental Security Income)
- ┆ WCDP (Wisconsin Chronic Disease Program)
- ┆ WWP (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 and 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 (for example, 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 (for example, 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 (for example, they may do member enrollment verification for one Portal account and HealthCheck inquiries 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 (for example, 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 (for example, 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 (for example, 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 email 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 email 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 email subscription, click Register for Email Subscription in the Quick Links box on the Provider page of the Portal.

WiCall

Topic #6257

Entering Letters into WiCall

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