Certification and Ongoing Responsibilities

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Certification and Ongoing Responsibilities:Certification

A Comprehensive Overview

BadgerCare Plus and Medicaid home health services refer to policies for the following services provided by home health agencies:

- Home health skilled nursing services.
- PDN services.
- Home health aide services.
- Home health therapy services.
- DME.
- DMS.

Home health agencies also certified to provide personal care services also are required to follow the policies and procedures as stated in the Personal Care service area.

Border Status Providers

A provider in a state that borders Wisconsin may be eligible for border-status certification. Border-status providers need to notify ForwardHealth in writing that it is common practice for members in a particular area of Wisconsin to seek their medical services.

Exceptions to this policy include:

- Nursing homes and public entities (e.g., cities, counties) outside Wisconsin are not eligible for border status.
- All out-of-state independent laboratories are eligible to be border-status providers regardless of location in the United States.

Providers who have been denied Medicaid certification in their own state are automatically denied certification by Wisconsin Medicaid unless they were denied because the services they provide are not a covered benefit in their state.

Certified border-status providers are subject to the same program requirements as in-state providers, including coverage of services and PA and claims submission procedures. Reimbursement is made in accordance with ForwardHealth policies.

For more information about out-of-state providers, refer to DHS 105.48, Wis. Admin. Code.

Categories of Certification

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

- Billing/rendering provider.
- Rendering provider.
- Group billing that requires a rendering provider.
- Group billing that does not require a rendering provider.

Providers should refer to their certification materials or to service-specific information in the Online Handbook to identify what types of certification categories they may apply for or be assigned.

Billing/Rendering Provider

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

Rendering Provider

Certification as a rendering provider is given to those providers who practice under the professional supervision of another provider (e.g., physician assistants). Providers with a rendering provider certification cannot submit claims to ForwardHealth directly, but 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.

Group Billing

Certification as a group billing provider is issued primarily as an accounting convenience. This allows a group billing provider to receive one reimbursement, one RA, and the 835 transaction for covered services rendered by individual providers within the group.

Group Billing That Requires a Rendering Provider

Individual providers within certain groups are required to be Medicaid certified 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.

Group Billing That Does Not Require a Rendering Provider

Other groups (e.g., physician pathology, radiology groups, and rehabilitation agencies) are not required to indicate a rendering provider on claims.

Group billing providers should refer to their certification materials or to service-specific information in the Online Handbook to determine whether or not a rendering provider is required on claims.

Certification Application

To participate in Wisconsin Medicaid, providers are required to be certified by Wisconsin Medicaid as described in DHS 105, Wis. Admin. Code. Providers certified by Wisconsin Medicaid may render services to members enrolled in Wisconsin Medicaid, BadgerCare Plus, and SeniorCare.

Providers interested in becoming certified by Wisconsin Medicaid are required to complete a provider application that consists of the following forms and information:

- General certification information.
- Certification requirements.
- TOR.
- Provider application.
- Provider Agreement and Acknowledgement of Terms of Participation.
- Other forms related to certification.

Providers may submit certification applications by mail or through the ForwardHealth Portal.

General Certification Information

This section of the provider application contains information on contacting ForwardHealth, certification effective dates, notification of certification decisions, provider agreements, and terms of reimbursement.

Certification Requirements

Wisconsin Administrative Code contains requirements that providers must meet in order to be certified with Wisconsin Medicaid; applicable Administrative Code requirements and any special certification materials for the applicant's provider type are included in the certification requirements document.

To become Medicaid certified, providers are required to do the following:

- Meet all certification requirements for their provider type.
- Submit a properly completed provider application, provider agreement, and other forms, as applicable, that are included in the certification packet.

Providers should carefully complete the certification materials and send all applicable documents demonstrating that they meet the stated Medicaid certification criteria. Providers may call Provider Services for assistance with completing these materials.

Terms of Reimbursement

Wisconsin Medicaid certification materials include Wisconsin Medicaid's TOR, which describes the methodology by which providers are reimbursed for services provided to BadgerCare Plus, Medicaid, and SeniorCare members. Providers should retain a copy of the TOR in their files. TOR are subject to change during a certification period.

Provider Application

A key part of the certification process is the completion of the Wisconsin Medicaid Provider Application. On the provider application, the applicant furnishes contact, address, provider type and specialty, license, and other information needed by Wisconsin Medicaid to make a certification determination.

Provider Agreement and Acknowledgement of Terms of Participation

As part of the application for certification, providers are required to sign a provider agreement with the DHS. Providers applying for certification through the Portal will be required to print, sign and date, and send the provider agreement to Wisconsin Medicaid. Providers who complete a paper provider application will need to sign and date the provider agreement and submit it with the other certification materials.

By signing a provider agreement, the provider certifies that the provider and each person employed by the provider, for the purpose of providing services, holds all licenses or similar entitlements and meets other requirements specified in DHS 101 through DHS 109, Wis. Admin. Code, and required by federal or state statute, regulation, or rule for the provision of the service.

The provider's certification to participate in Wisconsin Medicaid may be terminated by the provider as provided at DHS 106.05, Wis. Admin. Code, or by the DHS upon grounds set forth in DHS 106.06, Wis. Admin. Code.

This provider agreement remains in effect as long as the provider is certified to participate in Wisconsin Medicaid.

Certification for Private Duty Nursing for Ventilator-Dependent Members

To be eligible for reimbursement from Wisconsin Medicaid for PDN services provided to ventilator-dependent members residing at home, home health agencies are required to indicate in their request for certification their interest in providing this service. Providers are also required to submit the Wisconsin Medicaid Program Respiratory Care Services Affidavit, which can be found in the certification packet for home health agency providers.

Completing Certification Applications

Health care providers are required to include their NPI on the certification application.

Note: Obtaining an NPI does not replace the Wisconsin Medicaid certification process.

Portal Submission

Providers may apply for Medicaid certification directly through the ForwardHealth Portal. Though the provider certification application is available via the public Portal, the data are entered and transmitted through a secure connection to protect personal data. Applying for certification through the Portal offers the following benefits:

- Fewer returned applications. Providers who apply through the Portal are taken through a series of screens that are designed to guide them through the application process. This ensures that required information is captured and therefore reduces the instances of applications returned for missing or incomplete information.
- Instant submission. At the end of the online application process, applicants instantly submit their application to ForwardHealth and are given

an ATN to use in tracking the status of their application.
- Indicates documentation requirements. At the end of the online process, applicants are also given detailed instructions about what actions are needed to complete the application process. For example, the applicant will be instructed to print the provider agreement and any additional forms that Wisconsin Medicaid must receive on paper and indicates whether supplemental information (e.g., transcripts, copy of license) is required. Applicants are also able to save a copy of the application for their records.

Paper Submission

Providers may also submit provider applications on paper. To request a paper provider application, providers should do one of the following:

- Contact Provider Services.
- Click the "Contact Us" link on the Portal and send the request via e-mail.
- Send a request in writing to the following address:

  ForwardHealth
  Provider Maintenance
  6406 Bridge Rd
  Madison WI 53784-0006

Written requests for certification materials must include the following:

- The number of provider applications requested and each applicant's/provider's name, address, and telephone number (a provider application must be completed for each applicant/provider).
- The provider's NPI (for health care providers) that corresponds to the type of application being requested.
- The program for which certification is requested (Wisconsin Medicaid).
- The type of provider (e.g., physician, physician clinic or group, speech-language pathologist, hospital) or the type of services the provider intends to provide.

Paper provider applications are assigned an ATN at the time the materials are requested. As a result, examples of the provider application are available on the Portal for reference purposes only. These examples should not be downloaded and submitted to Wisconsin Medicaid. For the same reason, providers are not able to make copies of a single paper provider application and submit them for multiple applicants. These policies allow Wisconsin Medicaid to efficiently process and track certifications and assign effective dates.

Once completed, providers should mail certification materials to the address indicated on the application cover letter. Sending certification materials to any other Wisconsin Medicaid address may cause a delay.

Effective Date of Medicaid Certification

When assigning an initial effective date, ForwardHealth follows these regulations:

1. The date the provider submits his or her online provider application to ForwardHealth or contacts ForwardHealth for a paper application is the earliest effective date possible and will be the initial effective date if the following are true:
   - The provider meets all applicable licensure, certification, authorization, or other credential requirements as a prerequisite for Wisconsin Medicaid on the date of notification. Providers should not hold their application for pending licensure, Medicare, or other required certification but submit it to ForwardHealth. ForwardHealth will keep the provider's application on file and providers should send ForwardHealth proof of eligibility documents immediately, once available, for continued processing.
   - ForwardHealth received the provider agreement and any supplemental documentation within 30 days of submission of the online provider application.
   - ForwardHealth received the paper application within 30 days of the date the paper application was mailed.
2. If ForwardHealth receives the provider agreement and any applicable supplemental documents more than 30 days after the provider submitted the online application or receives the paper application more than 30 days after the date the paper application was mailed, the provider's effective date will be the date the complete application was received at ForwardHealth.
3. If ForwardHealth receives the provider's application within the 30-day deadline described above and it is incomplete or unclear, the provider will be granted one 30-day extension to respond to ForwardHealth's request for additional information. ForwardHealth must receive a response to the request for additional information within 30 days from the date on the letter requesting the missing information or item(s). This extension allows the provider additional time to obtain proof of eligibility (such as license verification, transcripts, or other certification).
4. If the provider does not send complete information within the original 30-day deadline or 30-day extension, the initial effective date will be

based on the date ForwardHealth receives the complete and accurate application materials.

Group Certification Effective Dates

Group billing certifications (formerly called group billing provider numbers) are given as a billing convenience. Groups (except providers of mental health services) may submit a written request to obtain group billing certification with a certification effective date back 365 days from the effective date assigned. Providers should mail requests to backdate group billing certification to the following address:

ForwardHealth
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Request for Change of Effective Date

If providers believe their initial certification effective date is incorrect, they may request a review of the effective date. The request should include documentation that indicates the certification criteria that were incorrectly considered. Requests for changes in certification effective dates should be sent to Provider Maintenance.

Medicare Enrollment

ForwardHealth requires certain types of providers to be enrolled in Medicare as a condition for Medicaid certification. This requirement is specified in the certification materials for these provider groups.

The enrollment process for Medicare is separate from Wisconsin Medicaid's certification process. Providers applying for Medicare enrollment *and* Medicaid certification are encouraged to apply for Wisconsin Medicaid certification at the same time they apply for Medicare enrollment, even though Medicare enrollment must be finalized first. By applying for Medicare enrollment and Medicaid certification simultaneously, it may be possible for ForwardHealth to assign a Medicaid certification effective date that is the same as the Medicare enrollment date.

Home Health Agency Certification Requirements

A home health agency is required to be certified by Wisconsin Medicaid to be eligible for reimbursement by Wisconsin Medicaid for providing services. A certification packet for home health services providers may be obtained on the ForwardHealth Portal.

To obtain Wisconsin Medicaid certification, a home health agency is required to meet all of the following as stated in DHS 105.16, Wis. Admin. Code:

- Be certified to participate in Medicare as a home health agency.
- Be licensed pursuant to DHS 133, Wis. Admin. Code.
- Provide part-time, intermittent skilled nursing services performed by a RN or LPN and home health aide services. Agencies may also provide other home health services such as PT, OT, SLP, DMS, and DME.
- All home health services must be provided in the member's home. Services may not be provided in a hospital or nursing home.
- All home health services must be provided in accordance with orders from the member's physician in a written POC that the physician reviews, dates, and signs at least every 62 days or when the member's medical condition changes, whichever occurs first.

In addition, home health agency responsibilities, as specified in DHS 105.16, Wis. Admin. Code, must be followed in order to maintain Wisconsin Medicaid certification.

Home health agencies with multiple locations also have additional certification responsibilities.

No separate certification is necessary for a Medicaid-certified home health agency to provide PDN, DME, DMS, or enteral nutrition products. The DME service area, the DMS service area, and the Enteral Nutrition Products service area contain more information about covered serivces, PA guidelines, and billing instructions.

Medicaid program requirements may not be construed to supersede the provisions for registration or licensure under s. 50.49, Wis. Stats. Refer to the Department of Regulation and Licensing Web site and the Department of Health Services Licensing and Permitting Web site for more information about registration and licensure requirements.

Materials for New Providers

On an ongoing basis, providers should refer to the Online Handbook for the most current BadgerCare Plus and Medicaid information. Future changes to policies and procedures are published in *Updates*.

Certain providers may opt not to receive these materials by completing the Deletion from Publications Mailing List form in the certification materials. Providers who opt out of receiving publications are still bound by ForwardHealth's rules, policies, and regulations even if they choose not to receive *Updates* on an ongoing basis. *Updates* are available for viewing and downloading on the ForwardHealth Portal.

Multiple Locations

The number of Medicaid certifications allowed or required per location is based on licensure, registration, certification by a state or federal agency, or an accreditation association identified in the Wisconsin Administrative Code. Providers with multiple locations should inquire if multiple applications must be completed when requesting a Medicaid certification application.

Multiple Services

Providers who offer a variety of services may be required to complete a separate Medicaid certification packet for each specified service/provider type.

Health care providers who are federally required to have an NPI are responsible for obtaining the appropriate certification for their NPI.

If a Medicaid-certified provider begins offering a new service *after* he or she has become initially certified, it is recommended that he or she call Provider Services to inquire if another application must be completed.

Noncertified In-State Providers

Wisconsin Medicaid reimburses noncertified in-state providers for providing emergency medical services to a member or providing services to a member during a time designated by the governor as a state of emergency. The emergency situation or the state of emergency must be sufficiently documented on the claim. Reimbursement rates are consistent with rates for Wisconsin Medicaid-certified providers rendering the same service.

Claims from noncertified in-state providers must be submitted with an In-State Emergency Provider Data Sheet. The In-State Emergency Provider Data Sheet provides ForwardHealth with minimal tax and licensure information.

Noncertified in-state providers may call Provider Services with questions.

Notice of Certification Decision

Wisconsin Medicaid will notify the provider of the status of the certification usually within 10 business days, but no longer than 60 days, after receipt of the complete application for certification. Wisconsin Medicaid will either approve the application and issue the certification or deny the application. If the application for certification is denied, Wisconsin Medicaid will give the applicant reasons, in writing, for the denial.

Providers who meet the certification requirements will be sent a welcome letter and a copy of the signed provider agreement. Included with the letter is an attachment with important information such as effective dates, assigned provider type and specialty, and taxonomy code. This information will be used when conducting business with BadgerCare Plus, Medicaid, or SeniorCare (for example, health care providers will need to include their taxonomy code, designated by Wisconsin Medicaid, on claim submissions and requests for PA).

The welcome letter will also notify non-healthcare providers (e.g., SMV providers, personal care agencies, blood banks) of their Medicaid provider number. This number will be used on claim submissions, PA requests, and other communications with ForwardHealth programs.

Out-of-State Providers

Out-of-state providers are limited to those providers who are licensed in the United States (and its territories), Mexico, and Canada. Out-of-state

providers are required to be licensed in their own state of practice.

Wisconsin Medicaid reimburses out-of-state providers for providing emergency medical services to a BadgerCare Plus or Medicaid member or providing services to a member during a time designated by the governor as a state of emergency. The emergency situation or the state of emergency must be sufficiently documented on the claim. Reimbursement rates are consistent with rates for Wisconsin Medicaid-certified providers providing the same service.

Out-of-state providers are reimbursed for services provided to eligible BadgerCare Plus or Medicaid members in either of the following situations:

- The service was provided in an emergency situation, as defined in DHS 101.03(52), Wis. Admin. Code.
- PA was obtained from ForwardHealth *before* the nonemergency service was provided.

Claims from noncertified out-of-state providers must be submitted with an Out-of-State Provider Data Sheet. The Out-of-State Provider Data Sheet provides Wisconsin Medicaid with minimal tax and licensure information.

Out-of-state providers may contact Provider Services with questions.

Personal Care Services Certification

Home health agencies planning to bill personal care services in addition to home health services are required to request certification for both service areas. Providers should refer to the Personal Care service area for further information about providing personal care services.

Provider Addresses

ForwardHealth interChange has the capability of storing the following types of addresses and related information, such as contact information and telephone numbers:

- *Practice location address and related information (formally known as physical address).* 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 telephone number for member's use. With limited exceptions, the practice location and telephone number for member's 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 concise address information to aid in proper mail delivery.
- *PA address.* This address is where ForwardHealth will mail PA information.
- *Financial addresses (formally known as payee address).* Two separate financial addresses are stored in ForwardHealth interChange. The checks and RA address is where Wisconsin Medicaid will mail checks and RAs. The 1099 mailing address is where Wisconsin Medicaid will mail IRS Form 1099.

Providers may submit additional address information or modify their current information through the ForwardHealth Portal or by using the Provider Change of Address or Status form.

Note: Providers are cautioned that any changes to their practice location on file with ForwardHealth may alter their ZIP+4 code information required on transactions. Providers may verify the ZIP+4 code for their address on the U.S. Postal Service Web site.

Provider addresses are stored separately for each program (i.e., Medicaid, WCDP, and WWWP) for which the provider is certified. Providers should consider this when supplying additional address information and keeping address information current. Providers who are certified for multiple programs and have an address change that applies to more than one program should provide this information for each program. Providers who submit these changes on paper need to submit *one* Provider Change of Address or Status form if changes are applicable for multiple programs.

Provider Type and Specialty Changes

Providers who want to add a certification type or make a change to their certification type should call Provider Services

Health care providers who are federally required to have an NPI are cautioned that any changes to their provider type and/or specialty information on file with ForwardHealth may alter the applicable taxonomy code for a provider's certification.

Recertification

Periodically, ForwardHealth conducts provider recertifications that require providers to update their information. Providers will be notified when they need to be recertified and will be provided with instructions on how to complete the recertification process.

Reinstating Certification

Providers whose Medicaid certification has ended for any reason other than sanctions or failure to be recertified may have their certification reinstated as long as all licensure and certification requirements are met. The criteria for reinstating certification vary, depending upon the reason for the cancellation and when the provider's certification ended.

If it has been less than 365 days since a provider's certification has ended, the provider is required to submit a letter or the Provider Change of Address or Status form, stating that he or she wishes to have his or her Medicaid certification reinstated.

If it has been more than 365 days since a provider's certification has ended, the provider is required to submit new certification materials. This can be done by completing them through the ForwardHealth Portal or submitting a paper provider application.

Termination of Provider Certification

A provider's Wisconsin Medicaid certification may be terminated for failure to comply with the certification and covered services requirements specified in the following:

- DHS 105.16, Wis. Admin. Code.
- DHS 107.11, Wis. Admin. Code.
- DHS 107.113, Wis. Admin. Code.
- DHS 107.12, Wis. Admin. Code.

In addition, a provider's Medicaid certification may be terminated for any of the reasons described in DHS 106.06, Wis. Admin. Code.

In accordance with DHS 106.065(1)(c), Wis. Admin. Code, providers terminated for failure to comply with these requirements have 30 calendar days from the date of termination of certification to make alternative care arrangements for BadgerCare Plus and Medicaid members under their care prior to the effective date of termination. After the 30-day period, payment for services will stop, except for payments to providers terminated in situations where the member's health and/or safety is in immediate jeopardy.

At least 15 working days advance notice of termination is required to be provided to the provider, except in situations where the member's health and/or safety is in immediate jeopardy. In these situations, at least five calendar days advance notice is provided to the provider, as specified in DHS 106.065(1)(b), Wis. Admin. Code. As determined by BadgerCare Plus and Medicaid, alternative care arrangements may also be made in order to provide continuity of care and protect the member, as stated in DHS 106.065(1)(c), Wis. Admin. Code.

Tracking Certification Materials

Wisconsin Medicaid allows providers to track the status of their certification application either through the ForwardHealth Portal or by calling Provider Services. Providers who submitted their application through the Portal will receive the ATN upon submission, while providers who request certification materials from Wisconsin Medicaid will receive an ATN on the application cover letter sent with their provider application. Regardless of how certification materials are submitted, providers may use one of the methods listed to track the status of their certification application.

Note: Providers are required to wait for the Notice of Certification Decision as official notification that certification has been approved. This notice will contain information the provider needs to conduct business with BadgerCare Plus, Medicaid, or SeniorCare; therefore, an approved or enrolled status alone does not mean the provider may begin providing or billing for services.

Tracking Through the Portal

Providers are able to track the status of a certification application through the Portal. By clicking on the "Certification Tracking Search" quick link

in the Provider area of the Portal and entering their ATN, providers will receive current information on their application, such as whether it's being processed or has been returned for more information.

Tracking Through Provider Services

Providers may also check on the status of their submitted application by contacting Provider Services and giving their ATN.

Documentation

1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than $600.00, per 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 share the same tax identification number. For example, a provider who conducts business with both Medicaid and WCDP will receive separate 1099 Miscellaneous forms for each program.

The 1099 Miscellaneous forms are sent to the address designated as the "1099 mailing address." The address formerly known as the "payee address" is used as the 1099 mailing address unless a provider has reported a separate address for the 1099 mailing address to ForwardHealth.

Availability of Records to Authorized Personnel

The DHCAA has the right to inspect, review, audit, and reproduce provider records pursuant to DHS 106.02(9)(e), Wis. Admin. Code. The DHCAA periodically requests provider records for compliance audits to match information against ForwardHealth's information on paid claims, PA 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 DHCAA staff member(s).

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

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

Also, state-contracted MCOs, including HMOs and SSI HMOs, are not reimbursed for the reproduction costs covered in their contract with the DHS.

The reproduction of records requested by the PRO under contract with the DHCAA is reimbursed at a rate established by the PRO.

Confidentiality

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. Therefore, use or disclosure of any information concerning applicants and members for any purpose not connected with program administration, including contacts with third-party payers that are necessary for pursuing third-party payment and the release of information as ordered by the court, is prohibited unless authorized by the applicant or member.

To comply with the standards, providers are required to follow the procedures outlined in the Online Handbook to ensure the proper release of this information. ForwardHealth providers, like other health care providers, are also subject to other laws protecting confidentiality of health care information including, but not limited to, the following:

- s. 146.81-146.84, Wis. Stats., Wisconsin health care confidentiality of health care information regulations.
- 42 USC s. 1320d - 1320d-8 (federal HIPAA) and accompanying regulations.

Any person violating this regulation may be fined an amount from $25 up to $500 or imprisoned in the county jail from 10 days up to one year, or both, for each violation.

A provider is not subject to civil or criminal sanctions when releasing records and information regarding applicants or members if such release is for purposes directly related to administration or if authorized in writing by the applicant or member.

Financial Records

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

ForwardHealth Review

Home health providers are required to make documentation and financial records available to ForwardHealth for review upon request in accordance with DHS 105.16(9), Wis. Admin. Code. Examples of these types of records include, but are not limited to, the following:

- Clinical notes.
- Personnel files.
- POCs.
- PA requests.
- Progress notes.
- Protocols.
- Timesheets.

As part of a review, ForwardHealth may contact members who have received or are receiving services from a home health provider. Providers are required to provide any identifying information about the member requested by ForwardHealth. ForwardHealth personnel may visit a chosen member with the member's or legal representative's approval. The member has the opportunity to have any person he or she chooses present during the visit. ForwardHealth may investigate any complaint that is received concerning the provision of services by a provider.

Medical Records

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

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.

Preparation and Maintenance of Records

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

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, who are required to retain records for a minimum of six years from the date of payment.

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

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

Reviews and Audits

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

Records Requests

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

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

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 the member, the provider should send a copy of the requested billing information or medical claim records, along with the name and address of the requester, to the following address:

Department of Health Services
Casualty/Subrogation Program
PO Box 6243
Madison WI 53791

ForwardHealth will process and forward the requested information to the requester.

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 should 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 notice of the material furnished to the requester to Coordination of Benefits at the previously listed address with a copy of the signed release.

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, the provider is required to do the following:

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

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

Request for a Statement from a Dual Eligible

If the request is for an itemized statement from a dual eligible, pursuant to HR 2015 (Balanced Budget Act of 1997) s. 4311, a dual eligible has the right to request and receive an itemized statement from his or her Medicare-certified 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.

For More Information

For additional information about requests for billing information or medical claim records, providers should call Provider Services. Providers may also write to the following address:

Division of Health Services

Estate and Casualty Recovery Section
PO Box 309
Madison WI 53701-0309

Release of Billing Information to Government Agencies

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

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

Ongoing Responsibilities

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).

Availability of Records

All providers are required to maintain a member's original medical record or a copy that can be reproduced.

To ensure continuity of care, providers are strongly encouraged to leave a copy of the member's original medical record in the member's home. Providers should also make a copy of the medical record available at the request of the member or the member's legal representative. Members have a right to a copy of their medical records and are not responsible for maintaining the agency's copy of their records.

Change in Ownership

New certification materials, including a provider agreement, must be completed whenever a change in ownership occurs. ForwardHealth defines a "change in ownership" as when a different party purchases (buys out) or otherwise obtains ownership or effective control over a practice or facility. Examples of a change in ownership include the following:

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

The following provider types require Medicare enrollment and/or DQA certification for Wisconsin Medicaid certification change in ownerships:

- Ambulatory surgery centers.
- ESRD services providers.
- Federally qualified health centers.
- Home health agencies.
- Hospice providers.
- Hospitals (inpatient and outpatient).
- Nursing homes.
- Outpatient rehabilitation facilities.
- Rehabilitation agencies.
- RHCs.

All changes in ownership must be reported in writing to ForwardHealth and new certification materials must be completed *before* the effective date of the change. The affected provider numbers should be noted in the letter. When the change in ownership is complete, the provider(s) will receive written notification of his or her provider number and the new Medicaid certification effective date in the mail.

Providers with questions about change in ownership should call Provider Services.

Repayment Following Change in Ownership

Medicaid-certified providers who sell or otherwise transfer their business or business assets are required to repay ForwardHealth for any erroneous payments or overpayments made to them by Wisconsin Medicaid. If necessary, the provider to whom a transfer of ownership is made will also be held liable by ForwardHealth for repayment. Therefore, prior to final transfer of ownership, the provider acquiring the business is responsible for contacting ForwardHealth to ascertain if he or she is liable under this provision.

The provider acquiring the business is responsible for making payments within 30 days after receiving notice from the DHS that the amount shall be repaid in full.

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

Division of Health Care Access and Accountability
Bureau of Program Integrity
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 s. 49.45(21), Wis. Stats., for complete information.

Civil Rights Compliance (Nondiscrimination)

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

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

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

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

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

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

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

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

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

For more information on the acts protecting members from discrimination, refer to the civil rights compliance information in the Enrollment and

Benefits booklet. The booklet is given to new ForwardHealth members by local county or tribal agencies. Potential ForwardHealth members can request the booklet by calling Member Services.

Title VI of the Civil Rights Act of 1964

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

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

Title VII of the Civil Rights Act of 1964

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

Federal Rehabilitation Act of 1973, Section 504

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

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

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

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

Americans with Disabilities Act of 1990

Under Title III of the ADA of 1990, any provider that operates an existing public accommodation has four specific requirements:

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

Age Discrimination Act of 1975

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

Contracted Staff

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

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

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

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

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

Discharge of Members

A home health agency may not discharge a member for any reason until the agency has discussed the details of the discharge with the member, or the member's legal representative, and the member's physician. Refer to DHS 133.09, Wis. Admin. Code, for details concerning the discharge of members.

Distribution of Private Duty Nursing Information

Home health agencies providing PDN services are strongly encouraged to photocopy and distribute the brochure titled *Wisconsin Medicaid Private Duty Nursing — A Guide for Wisconsin Medicaid Recipients and Their Families* to all members and their families. The brochure helps providers explain the following:

- The extent and limitations of the PDN benefit.
- The PA process.
- The rights and responsibilities of PDN members and their families.
- The course of action available to members and their families who are dissatisfied with PDN services covered under BadgerCare Plus and Medicaid.

Examples of Ongoing Responsibilities

Responsibilities for which providers are held accountable are described throughout the Online Handbook. Medicaid-certified 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 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, financial records, along with other documentation, for a period of not less than five years from the date of payment, except rural health clinic providers who are required to retain records for a minimum of six years from the date of payment.
- Billing only for services that were actually provided.
- Allowing a member access to his or her records.
- Monitoring contracted staff.
- Accepting Medicaid reimbursement as payment in full for covered services.

- Keeping provider information (i.e., address, business name) current.
- Notifying ForwardHealth of changes in ownership.
- Responding to Medicaid recertification notifications.
- Safeguarding member confidentiality.
- Verifying member enrollment.
- Keeping up-to-date with changes in program requirements as announced in ForwardHealth publications.

Keeping Information Current

Types of Changes

Providers are required to notify ForwardHealth of changes, including the following:

- Address(s) — practice location and related information, mailing, PA, and/or financial.
- Telephone number, including area code.
- Business name.
- Contact name.
- Federal Tax ID number (IRS number).
- Group affiliation.
- Licensure.
- Medicare NPI for health care providers or Medicare provider number for providers of *non-healthcare* services.
- Ownership.
- Professional certification.
- Provider specialty.
- Supervisor of nonbilling providers.

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

- Incorrect reimbursement.
- Misdirected payment.
- Claim denial.
- Suspension of payments in the event that 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.

Address Changes

Healthcare providers who are federally reuired to have an NPI 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.

Submitting Changes in Address or Status

Once certified, providers are required to submit changes in address or status as they occur, either through the Portal or on paper.

ForwardHealth Portal Submission

After establishing a provider account on the ForwardHealth Portal, providers may make changes to their demographic information online. Changes made through the Portal instantly update the provider's information in ForwardHealth interChange. In addition, since the provider is allowed to make changes directly to his or her information, the process does not require re-entry by ForwardHealth.

Providers should note, however, that the demographic update function of the Portal limits certain providers from modifying some types of information. Providers who are not able to modify certain information through the Portal may make these changes using the Provider Change of Address or Status form.

Paper Submission

Providers must use the Provider Change of Address or Status form. Copies of old versions of this form will not be accepted and will be returned

to the provider so that he or she may complete the current version of the form or submit changes through the Portal.

Change Notification Letter

When a change is made to certain provider information, either through the use of the Provider Change of Address or Status form or through the Portal, ForwardHealth will send a letter notifying the provider of the change(s) made. Providers should carefully review the Provider File Information Change Summary included with the letter. If any information on this summary is incorrect, providers may do one of the following:

- If the provider made an error while submitting information on the Portal, he or she should correct the information through the Portal.
- If the provider submitted incorrect information using the Provider Change of Address or Status form, he or she should either submit a corrected form or correct the information through the Portal.
- If the provider submitted correct information on the Provider Change of Address or Status form and believes an error was made in processing, he or she can contact Provider Services to have the error corrected or submit the correct information via the Portal.

Notify Division of Quality Assurance of Changes

Providers licensed or certified by the DQA are required to notify the DQA of changes to physical address, changes of ownership, and facility closures by calling (608) 266-8481.

Providers licensed or certified by the DQA are required to notify the DQA of these changes *before* notifying ForwardHealth. The DQA will then forward the information to ForwardHealth.

Legal Framework

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

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

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

The information included in the ForwardHealth Portal applies to BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid. BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid are administered by the DHS. Within the DHS, the DHCAA is directly responsible for managing these programs.

The following laws and regulations provide the legal framework for the program requirements of home health agencies:

- Sections 49.46(2)(b)6m, 49.47(6)(a)1, 448.05, and 448.07, Wis. Stats.
- Chapters DHS 105.16, 107.11, 107.113, 107.12, and 133 and N 6.03 and 6.04, Wis. Admin. Code.

Submitting Cost Reports

The WIMCR initiative is a cost-based payment system for counties certified as Medicaid providers of community-based services that provides additional funding for Wisconsin Medicaid while remaining cost neutral for counties.

All counties certified as Medicaid providers of community-based services are required to submit cost reports to ForwardHealth. Cost reports are required under WIMCR for the following services provided and billed to Wisconsin Medicaid by county providers:

- Case management services.
- Child/adolescent day treatment.
- Community support program services.
- Home health services.

- Medical day treatment services.
- Mental health crisis intervention services.
- Outpatient mental health and substance abuse services, including evaluation, psychotherapy, and substance abuse counseling and intensive in-home mental health services for children under HealthCheck.
- Outpatient mental health and substance abuse services provided in the home and community. (The non-federal share of this service is provided by the county.)
- Personal care services.
- PNCC services.
- Substance abuse day treatment.

If Wisconsin Medicaid is not billed by the county for case management services, no cost report is required.

Cost Reporting Web Tool

Counties are required to submit cost reports online by using the WIMCR Web tool. After registering on the Web site, the user will be directed to the WIMCR home page where the following information is located:

- Certification of Medicaid Operating Deficit and Application for Distribution of Federal Financial Participation.
- Past WIMCR Cost Reports.
- The WIMCR Cost Report Instruction Manual.
- Other WIMCR reference documents.

WIMCR Initiative Information

For further information about the WIMCR initiative, refer to the document titled, "Questions and Answers Regarding Wisconsin Medicaid Cost Reporting Including Medicaid Payments, CSDRB, CBMAC, and the State/County Contracts."

Written Statement of Member Rights

In accordance with DHS 133.08(2), Wis. Admin. Code, all home health agencies are required to furnish a written statement of member rights to the members they serve. Providers are required to share the statement with the member or their legal representative prior to providing services.

The member or legal representative is required to acknowledge the receipt of the statement of member rights in writing, and the statement must be included in the member's medical record.

Each member of home health services has rights that include, but are not limited to, the following:

- Being fully informed of all of his or her rights.
- Being fully informed of all rules and regulations governing member responsibilities.
- Being informed of all services and any changes in these services as they occur.
- Being informed of all charges for which the member may be responsible.
- Being fully informed of one's own health condition, unless medically contraindicated.
- Participating in the planning of services, including referral to health care institutions or other agencies.
- Refusing to participate in experimental research.
- Refusing treatment to the extent permitted by law and being informed of the medical consequences of such refusal.
- Confidential treatment of personal and medical records and approving or refusing their release to any individual outside the agency except in the case of transfer to a health care facility or as required by law or third-party payment contract.
- Being treated with consideration, respect, and full recognition of dignity and individuality.
- Being taught the treatment that is required so that the member can, to the extent possible, help himself or herself. Family, other persons living with the member, or other parties designated by the member will also be taught the treatment so that these persons can understand and assist the member.
- Complaining about the care that was provided or not provided, and seeking resolution of the complaint without fear of recrimination.

Provider Numbers

National Provider Identifier

Health care providers are required to indicate an NPI on electronic and paper transactions submitted to ForwardHealth.

The NPI is a 10-digit number obtained through NPPES.

Providers should ensure that they have obtained an appropriate NPI to correspond to their certification.

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 certifications — one certification as an individual physical therapist and the other certification as the physical therapy group. A Type 1 NPI for the individual certification and a Type 2 NPI for the group certification are required.

NPIs and classifications may be viewed on the NPPES Web site. The Centers for Medicare and Medicaid Services Web site includes more Type 1 and Type 2 NPI information.

Some providers hold multiple certifications with ForwardHealth. For example, a health care organization may be certified according to the type of services their organization provides (e.g., physician group, therapy group, home health agency) or the organization may have separate certification for each practice location. ForwardHealth maintains a separate provider file for each certification that stores information used for processing electronic and paper transactions (e.g., provider type and specialty, certification begin and end dates). When a single NPI is reported for multiple certifications, ForwardHealth requires additional data to identify the provider and to determine the correct provider file to use when processing transactions.

Either or both of the following additional data is required with NPI when a single NPI corresponds to multiple certifications:

- The ForwardHealth-designated taxonomy code.
- ZIP+4 code (complete, nine digits) that corresponds to the practice location address on file with ForwardHealth.

Omission of the additional required data will cause claims and other transactions to be denied or delayed in processing.

Taxonomy Codes

Taxonomy codes are standard code sets used to provide information about provider type and specialty for the provider's certification. Providers are required to use the taxonomy code designated by ForwardHealth when the NPI reported to ForwardHealth corresponds to multiple certifications and the provider's practice location ZIP+4 code does not uniquely identify the provider.

ForwardHealth designates a taxonomy code as additional data to be used to correctly match NPI to the correct provider file. The designated taxonomy code may be different than the taxonomy code providers originally submitted to NPPES when obtaining their NPI as not all national taxonomy code options are recognized by ForwardHealth. For example, some taxonomy codes may correspond to provider types not certifiable with ForwardHealth, or they may represent services not covered by ForwardHealth.

Omission of a taxonomy code when it is required as additional data to identify the provider or indicating a taxonomy code that is not designated by ForwardHealth will cause claims and other transactions to be denied or delayed in processing.

Refer to the ForwardHealth-designated taxonomy codes for the appropriate taxonomy code for your certification.

Note: The ForwardHealth-designated taxonomy code does not change provider certification or affect reimbursement terms.

ZIP Code

The ZIP+4 code is the ZIP code of a provider's practice location address on file with ForwardHealth. Providers are required to use the ZIP+4 code when the NPI reported to ForwardHealth corresponds to multiple certifications and the designated texonomy code does not uniquely identify the provider.

Omission of the ZIP+4 code of the provider's practice location address when it is required as additional data to identify the provider will cause claims and other transactions to be denied or delayed in processing.

Providers may verify the ZIP+4 code for their address on the U.S. Postal Service Web site.

Provider Rights

A Comprehensive Overview of Provider Rights

Medicaid-certified providers have certain rights including, but not limited to, the following:

- Limiting the number of members they serve in a nondiscriminatory way.
- Ending participation in Wisconsin Medicaid.
- Applying for a discretionary waiver or variance of certain rules identified in Wisconsin Administrative Code.
- Collecting payment from a member under limited circumstances.
- Refusing services to a member if the member refuses or fails to present a ForwardHealth identification card. However, possession of a ForwardHealth card does not guarantee enrollment (e.g., the member may not be enrolled, may be enrolled only for limited benefits, or the ForwardHealth card may be invalid). Providers may confirm the current enrollment of the member by using one of the EVS methods, including calling Provider Services.

Ending Participation

Providers other than home health agencies and nursing facilities may terminate participation in ForwardHealth according to DHS 106.05, Wis. Admin. Code.

Providers choosing to withdraw should promptly notify their members to give them ample time to find another provider.

When withdrawing, the provider is required to do the following:

- Provide a written notice of the decision at least 30 days in advance of the termination.
- Indicate the effective date of termination.

Providers will not receive reimbursement for nonemergency services provided on and after the effective date of termination. Voluntary termination notices can be sent to the following address:

ForwardHealth
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

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.

Hearing Requests

A provider who wishes to contest a DHS action or inaction for which due process is required under s. 227, Wis. Stats., may request a hearing by writing to the DHA.

A provider who wishes to contest the DHCAA's notice of intent to recover payment (e.g., to recoup for overpayments discovered in an audit by DHCAA) is required to request a hearing on the matter within the time period specified in the notice. The request, which must be in writing, should briefly summarize the provider's basis for contesting the DHS decision to withhold payment.

Refer to DHS 106, Wis. Admin. Code, for detailed instructions on how to file an appeal.

If a timely request for a hearing is not received, the DHS may recover those amounts specified in its original notice from future amounts owed to the provider.

Note: Providers are not entitled to administrative hearings for billing disputes.

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.

Requesting Discretionary Waivers and Variances

In rare instances, a provider or member may apply for, and the DHCAA will consider applications for, a discretionary waiver or variance of certain rules in DHS 102, 103, 104, 105, 107, and 108, Wis. Admin. Code. Rules that are not considered for a discretionary waiver or variance are included in DHS 106.13, Wis. Admin. Code.

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

Requirements

A request for a waiver or variance may be made at any time; however, all applications must be made in writing to the DHCAA. All applications are required to specify the following:

- The rule from which the waiver or variance is requested.
- The time period for which the waiver or variance is requested.
- If the request is for a variance, the specific alternative action proposed by the provider.
- The reasons for the request.
- Justification that all requirements for a discretionary waiver or variance would be satisfied.

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

Application

The DHCAA may grant a discretionary waiver or variance if it finds that all of the following requirements are met:

- The waiver or variance will not adversely affect the health, safety, or welfare of any member.
- Either the strict enforcement of a requirement would result in unreasonable hardship on the provider or on a member, or an alternative to a rule is in the interests of better care or management. An alternative to a rule would include a new concept, method, procedure or technique, new equipment, new personnel qualifications, or the implementation of a pilot project.
- The waiver or variance is consistent with all applicable state and federal statutes and federal regulations.
- Federal financial participation is available for all services under the waiver or variance, consistent with the Medicaid state plan, the federal CMS, and other applicable federal program requirements.
- Services relating to the waiver or variance are medically necessary.

To apply for a discretionary waiver or variance, providers are required to send their application to the following address:

Division of Health Care Access and Accountability
Waivers and Variances
PO Box 309
Madison WI 53701-0309

Sanctions

Intermediate Sanctions

According to DHS 106.08(3), Wis. Admin. Code, the DHS may impose intermediate sanctions on providers who violate certain requirements. Common examples of sanctions that the DHS may apply include the following:

- Review of the provider's claims before payment.
- Referral to the appropriate peer review organization, licensing authority, or accreditation organization.
- Restricting the provider's participation in BadgerCare Plus.
- Requiring the provider to correct deficiencies identified in a DHS audit.

Prior to imposing any alternative sanction under this section, the DHS will issue a written notice to the provider in accordance with DHS 106.12, Wis. Admin. Code.

Any sanction imposed by the DHS may be appealed by the provider under DHS 106.12, Wis. Admin. Code. Providers may appeal a sanction by writing to the DHA.

Involuntary Termination

The DHS may suspend or terminate the Medicaid certification of any provider according to DHS 106.06, Wis. Admin. Code.

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

- The DHS finds that any of the grounds for provider termination are applicable.
- The suspension or termination will not deny members access to services.

Reasonable notice and an opportunity for a hearing within 15 days will be given to each provider whose certification is terminated by the DHS. Refer to DHS 106.07, Wis. Admin. Code, for detailed information regarding possible sanctions.

In cases where Medicare enrollment is required as a condition of certification with Wisconsin Medicaid, termination from Medicare results in automatic termination from Wisconsin Medicaid.

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 certification. In addition, the provider may also be fined not more than $25,000, or imprisoned not more than five years, or both, pursuant to 42 USC s. 1320a-7b(d) or 49.49(3m), Wis. Stats.

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

Withholding Payments

The DHS may withhold full or partial Medicaid provider payments without prior notification if, as the result of any review or audit, the DHS finds reliable evidence of fraud or willful misrepresentation.

"Reliable evidence" of fraud or willful misrepresentation includes, but is not limited to, the filing of criminal charges by a prosecuting attorney against the provider or one of the provider's agents or employees.

The DHS is required to send the provider a written notice within five days of taking this action. The notice will generally set forth the allegations without necessarily disclosing specific information about the investigation.

Claims

2

Archive Date:07/01/2009

Claims:Adjustment Requests

Allowed Claim

An allowed claim (or adjustment request) contains at least one service that is reimbursable. Allowed claims display on the Paid Claims Section of the RA with a dollar amount greater than "0" in the allowed amount fields. Only an allowed claim, which is also referred to as a claim in an allowed status, may be adjusted.

Denied Claim

A claim that was completely denied is considered to be in a denied status. To receive reimbursement for a claim that was completely denied, it must be corrected and submitted as a new claim.

Electronic

Even if the original claim was submitted on paper, providers may submit electronic adjustment requests using an 837 transaction.

Provider Electronic Solutions Software

The DHCAA offers electronic billing software at no cost to providers. The PES software allows providers to submit electronic adjustment requests using an 837 transaction. To obtain PES software, providers may download it or contact the EDI Helpdesk.

Follow-Up

Providers who believe an error has occurred or their issues have not been satisfactorily resolved have the following options:

- Submit a new adjustment request if the previous adjustment request is in an allowed status.
- Submit a new claim for the services if the adjustment request is in a denied status.
- Contact Provider Services for assistance with paper adjustment requests.
- Contact the EDI Helpdesk for assistance with electronic adjustment requests.

Paper

Paper adjustment requests must be submitted using the Adjustment/Reconsideration Request form.

Processing

Within 30 days of receipt, ForwardHealth generally reprocesses the original claim with the changes indicated on the adjustment request and responds on ForwardHealth remittance information.

Purpose

After reviewing both the claim and ForwardHealth remittance information, a provider may determine that an allowed claim needs to be adjusted. Providers may file adjustment requests for reasons including the following:

- To correct billing or processing errors.
- To correct inappropriate payments (overpayments and underpayments).
- To add and delete services.
- To supply additional information that may affect the amount of reimbursement.
- To request professional consultant review (e.g., medical, dental).

Providers may initiate reconsideration of an allowed claim by submitting an adjustment request to ForwardHealth.

Submitting Paper Attachments with Electronic Claim Adjustments

Providers may submit paper attachments to accompany electronic claim adjustments. Providers should refer to their companion documents for directions on indicating that a paper attachment will be submitted by mail.

Good Faith Claims

Definition

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

Overpayments

Adjustment Request vs. Cash Refund

Except for nursing home and hospital providers, cash refunds may be submitted to ForwardHealth in lieu of an adjustment request. However, whenever possible, providers should submit an adjustment request for returning overpayments since both of the following are true:

- A cash refund does not provide documentation for provider records as an adjustment request does. (Providers may be required to submit proof of the refund at a later time.)
- Providers are not able to further adjust the claim after a cash refund is done if an additional reason for adjustment is determined.

Adjustment Requests

When correcting an overpayment through an adjustment request, providers may submit the adjustment request electronically or on paper. Providers should not submit provider-based billing claims through adjustment processing channels.

ForwardHealth processes an adjustment request if the provider is all of the following:

- Medicaid certified on the DOS.
- Not currently under investigation for Medicaid fraud or abuse.
- Not subject to any intermediate sanctions under DHS 106.08, Wis. Admin. Code.
- Claiming and receiving ForwardHealth reimbursement in sufficient amounts to allow the recovery of the overpayment within a very limited period of time. The period of time is usually no more than 60 days.

Electronic Adjustment Requests

ForwardHealth will deduct the overpayment when the electronic adjustment request is processed. Providers should use the companion document for the appropriate 837 transaction when submitting adjustment requests.

Paper Adjustment Requests

For paper adjustment requests, providers are required to do the following:

- Submit an Adjustment/Reconsideration Request form through normal processing channels (not Timely Filing), regardless of the DOS.
- Indicate the reason for the overpayment, such as a duplicate reimbursement or an error in the quantity indicated on the claim.

After the paper adjustment request is processed, ForwardHealth will deduct the overpayment from future reimbursement amounts.

Cash Refunds

When submitting a personal check to ForwardHealth for an overpayment, providers should include a copy of the RA for the claim to be adjusted and highlight the affected claim on the RA. If a copy of the RA is not available, providers should indicate the ICN, the NPI (if applicable), and the payee ID from the RA for the claim to be adjusted. The check should be sent to the following address:

ForwardHealth
Financial Services Cash Unit
6406 Bridge Rd
Madison WI 53784-0004

ForwardHealth-Initiated Adjustments

ForwardHealth may initiate an adjustment when a retroactive rate increase occurs or when an improper or excess payment has been made.

ForwardHealth has the right to pursue overpayments resulting from computer or clerical errors that occurred during claims processing.

If ForwardHealth initiates an adjustment to recover overpayments, ForwardHealth remittance information will include details of the adjustment in the Claims Adjusted Section of the paper RA.

Requirements

As stated in DHS 106.04(5), Wis. Admin. Code, the provider is required to refund the overpayment within 30 days of the date of the overpayment if a provider receives overpayment for a claim because of duplicate reimbursement from ForwardHealth or other health insurance sources.

In the case of all other overpayments (e.g., incorrect claims processing, incorrect maximum allowable fee paid), providers are required to return the overpayment within 30 days of the date of discovery.

The return of overpayments may occur through one of the following methods:

- Return of overpayment through the adjustment request process.
- Return of overpayment with a cash refund.
- ForwardHealth-initiated adjustments.

Note: Nursing home and hospital providers may not return an overpayment with a cash refund. These providers routinely receive retroactive rate adjustments, requiring ForwardHealth to reprocess previously paid claims to reflect a new rate. This is not possible after a cash refund is done.

Responses

An Overview of the Remittance Advice

The RA provides important information about the processing of claims and adjustment requests as well as additional financial transactions such as refunds or recoupment amounts withheld. Providers will receive an RA from the appropriate ForwardHealth program when they have at least one claim, adjustment request, or financial transaction processed. An RA is generated regardless of how a claim or adjustment is submitted (electronically or on paper).

An Overview of the Remittance Advice

Providers who have a single NPI that is used for multiple certifications will receive an RA for each certification with the same NPI reported on each of the RAs. For instance, if a hospital has obtained a single NPI and the hospital has a clinic, a lab, and a pharmacy that are all certified by Medicaid, the clinic, the lab, and the pharmacy will submit separate claims that indicate the same NPI as the hospital. Separate RAs will be generated for the hospital, the clinic, the lab, and the pharmacy.

Calculating Totals on the Remittance Advice for Adjusted and Paid Claims

The total amounts for all adjusted or paid claims reported on the RA appear at the end of the adjusted claims and paid claims sections. ForwardHealth calculates the total by adding the amounts for all of the claims; cutback amounts are subtracted from the allowed amount to reach the total reimbursement for the claims.

Note: Some cutbacks that are reported in detail lines will appear as EOB codes and will not display an exact dollar amount.

Claim Number

Each claim or adjustment request received by ForwardHealth is assigned a unique claim number (also known as the ICN). However, denied claims submitted using the NCPDP 5.1 transaction are not assigned an ICN.

Interpreting Claim Numbers

The ICN consists of 13 digits that identify valuable information (e.g., the date the claim was received by ForwardHealth, how the claim was submitted) about the claim or adjustment request.

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 system or the 276/277 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.

Cutback Fields on the Remittance Advice for Adjusted and Paid Claims

Cutback fields indicate amounts that reduce the allowed amount of the claim. Examples of cutbacks include other insurance, member copayment, spenddown amounts, deductibles, or patient liability amounts. Amounts indicated in a cutback field are subtracted from the total allowed reimbursement.

Providers should note that cutback amounts indicated in the header of an adjusted or paid claim section apply only to the header. Not all cutback fields that apply to a detail line (such as copayments or spenddowns) will be indicated on the RA; the detail line EOB codes inform providers that an amount was deducted from the total reimbursement but may not indicate the exact amount.

Note: Providers who receive 835 transactions will be able to see all deducted amounts on paid and adjusted claims.

Electronic Remittance Information

Electronic remittance information may be obtained using the 835 transaction. It provides useful information regarding the processing of claims and adjustment requests, which includes the status or action taken on a claim, claim detail, adjustment, or adjustment detail for all claims and adjustments processed that week, regardless of whether they are reimbursed or denied. However, a claim submitted by a pharmacy using the NCPDP 5.1 transaction will not appear on remittance information if the claim is denied by ForwardHealth.

Provider Electronic Solutions Software

The DHCAA offers electronic billing software at no cost to the provider. The PES software allows providers to download the 835 transaction. To obtain PES software, providers may request the software through the ForwardHealth Portal. Providers may also obtain the software by contacting the EDI Helpdesk.

Explanation of Benefit Codes in the Claim Header and in the Detail Lines

EOB codes are four-digit numeric codes specific to ForwardHealth that correspond to a printed message about the status or action taken on a claim, claim detail, adjustment, or adjustment detail.

The claim processing sections of the RA report EOBs for the claim header information and for the detail lines, as appropriate. Header information is a summary of the information from the claim, such as the DOS that the claim covers or the total amount paid for the claim. Detail lines report information from the claim details, such as specific procedure codes or revenue codes, the amount billed for each code, and the amount paid for a detail line item.

Header EOBs are listed below the claim header information and pertain only to the header information. Detail line EOBs are listed after each detail line and pertain only to the detail line.

Identifying the Claims Reported on the Remittance Advice

The RA reports the first 12 characters of the MRN and/or a PCN, also referred to as Patient Account Number, submitted on the original claims. The MRN and PCN fields are located beneath the member's name on any section of the RA that reports claims processing information.

Providers are strongly encouraged to enter these numbers on claims. Entering the MRN and/or the PCN on claims may assist providers in identifying the claims reported on the RA.

Note: Claims processing sections for dental and drug claims do not include the MRN or the PCN.

Obtaining the Remittance Advice

One paper copy of each RA is mailed to the provider.

Providers who receive the paper RA may also access RAs through their secure ForwardHealth Portal accounts. The main page of the secure Portal account lists the last 10 RAs issued to the provider.

Providers may choose to opt out of receiving a paper RA by sending a written request to the following address:

ForwardHealth

Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Note: Providers who do not receive a paper RA can not view the RA on the Portal. Providers who opt out of receiving the paper RA should make sure they receive the electronic 835 transaction.

Providers may obtain additional paper copies of the RA by sending a written request to the following address:

ForwardHealth
Written Correspondence
6406 Bridge Rd
Madison WI 53784-0005

Providers may call Provider Services to request additional paper copies of the RA.

Overview of Claims Processing Information on the Remittance Advice

The claims processing sections of the RA includes information submitted on claims and the status of the claims. The claim status designations are paid, adjusted, or denied. The RA also supplies information about why the claim was adjusted or denied or how the reimbursement was calculated for the payment.

The claims processing information in the RA is grouped by the type of claim and the status of the claim. Providers receive claims processing sections that correspond to the types of claims that have been finalized during the current financial cycle.

The claims processing sections reflect the types of claims submitted, such as the following:

- Compound drug claims.
- Dental claims.
- Drug claims.
- Inpatient claims.
- Long term care claims.
- Medicare crossover institutional claims.
- Medicare crossover professional claims.
- Outpatient claims.
- Professional claims.

The claims processing sections are divided into the following status designations:

- Adjusted claims.
- Denied claims.
- Paid claims.

Prior Authorization Number on the Remittance Advice

The RA reports PA numbers used to process the claim. PA numbers appear in the detail lines of claims processing information.

Reading Non-Claims Processing Sections of the Remittance Advice

Address Page

The Address page displays the provider name and "Pay to" address of the provider for purposes of mailing the paper RA.

Banner Messages

The Banner Messages section of the RA contains important, time-sensitive messages for providers. For example, banner messages might inform providers of claim adjustments initiated by ForwardHealth, claim submission deadlines, and dates of upcoming training sessions. It is possible for each RA to include different messages, so providers who receive multiple RAs should read all of their banner messages.

Explanation of Benefits Code Descriptions

The EOB Code Descriptions section lists all EOB codes reported on the RA with corresponding descriptions.

Financial Transactions Page

The Financial Transactions section details the provider's weekly financial activity. Financial transactions reported on the RA include payouts, refunds, accounts receivable, and payments for claims.

Payouts are payments made to the provider by ForwardHealth that do not correspond to a specific claim (i.e., nursing home assessment reimbursement).

Refunds are payments made to providers for overpayments.

The Accounts Receivable section displays the accounts receivable for amounts owed by providers. The accounts receivable is set to automatically recover any outstanding balance so that money owed is automatically recouped from the provider. If the full amount cannot be recouped during the current financial cycle, an outstanding balance will appear under "Accounts Receivable." The "Total Recoupment" field lists the cumulative amount recovered for the accounts receivable.

Every financial transaction that results in the creation of an accounts receivable is assigned an identification number called the "adjustment ICN." The adjustment ICN for an adjusted claim matches the original ICN assigned to the adjusted claim. For other financial transactions, the adjustment ICN is determined by the following formula.

Type of Character and Description	Applicable Characters and Description
Transaction — The first character indicates the type of financial transaction that created the accounts receivable.	V — Capitation adjustment 1 — OBRA Level 1 screening void request 2 — OBRA Nurse Aide Training/Testing void request
Identifier — 10 additional numbers are assigned to complete the Adjustment ICN.	The identifier is used internally by ForwardHealth.

Service Code Descriptions

The Service Code Descriptions section lists all the service codes (i.e., procedure codes or revenue codes) reported on the RA with their corresponding descriptions.

Summary

The Summary section reviews the provider's claim activity and financial transactions with the payer (Medicaid, WCDP, or WWWP) for the current financial cycle, the month-to-date, and the year-to-date, if applicable.

Under the "Claims Data" heading, providers can review the total number of claims that have been paid, adjusted, or denied along with the total amount reimbursed for all paid and adjusted claims. Only WWWP providers will see amounts reported for "Claims in Process." Other providers will always see zeroes in these fields.

Under the "Earnings Data" heading, providers will see total reimbursement amounts for other financial transactions, such as reimbursement for OBRA Level 1 screening, reimbursement for OBRA Nurse Aid Training/Testing, and capitation payments.

Note: HMOs should note that capitation payments are only reported in the Summary section of the RA. HMOs receive supplemental reports of their financial transactions from ForwardHealth.

The "Earnings Data" portion also summarizes refunds and voids and reports the net payment for the current financial cycle, the month-to-date, and the year-to-date, if applicable.

Providers should note that the Summary section will include outstanding checks 90 days after issuance and/or payments made to lien holders, if applicable.

Reading the Claim Adjustments Section of the Remittance Advice

Providers receive a Claim Adjustments section in the RA if any of their claims were adjusted during the current financial cycle. A claim may be adjusted because one of the following occurred:

- An adjustment request was submitted by the provider.
- ForwardHealth initiated an adjustment.
- A cash refund was submitted to ForwardHealth.

In a claim adjustments section, the original claim information in the claim header is surrounded by parentheses. Information about the adjusted claim appears directly below the original claim header information. Providers should check the Adjustment EOB code(s) for a summary of why the claim was adjusted; other header EOBs will provide additional information.

The claim adjustments section lists detail lines only for the adjusted claim with detail line EOBs. Details from the original claim will not be reported on the adjusted claims sections of the RA.

Note: For adjusted drug claims, only the compound drug sections include detail lines.

Below the claim header and the detail information will be located one of three possible responses with a corresponding dollar amount: "additional payment," "overpayment to be withheld," or "refund amount applied."

An amount appears for "additional payment" if ForwardHealth owes additional monies to the provider after the claim has been adjusted. This amount will be added to the provider's total reimbursable amount for the RA.

An amount appears for "overpayment to be withheld" if ForwardHealth determines, as the result of an adjustment to the original claim, that the provider owes ForwardHealth monies. ForwardHealth automatically withholds this amount from payments made to the provider during the same financial cycle or during subsequent financial cycles, if necessary. This amount also appears in the Financial Transactions section as an outstanding balance under "Accounts Receivable."

An amount appears for "refund amount applied" if ForwardHealth makes a payment to refund a cash receipt to a provider.

Reading the Claims Denied Section of the Remittance Advice

Providers receive a Claims Denied section in the RA if any of their claims were denied during the current financial cycle.

In the denied claims section, providers will see the original claim header information reported along with EOB codes for the claim header and the detail lines, as applicable. Providers should refer to the EOB Code Description section of the RA to determine why the claim was denied.

Reading the Claims Paid Section of the Remittance Advice

Providers receive a Claims Paid section in the RA if any of their claims were determined payable during the current financial cycle.

In a paid claims section, providers will see the original claim information reported along with EOB codes for both the header and the detail lines, if applicable. Providers should refer to the EOB Code Description section of the RA for more information about how the reimbursement amount was determined.

Remittance Advice Financial Cycles

Each financial payer (Medicaid, WCDP, and WWWP) has separate financial cycles that occur on different days of the week. RAs are produced and mailed to providers after each financial cycle is completed. Therefore, providers might receive RAs from different payers on different days of the week.

Certain financial transactions may run on a daily basis, including non-claim related payouts and stop payment reissues. Providers may receive the RAs generated by these financial transactions at any time during the week.

Remittance Advice Generated by Payer and by Provider Certification

Providers may receive an RA from one or more of the following ForwardHealth financial payers:

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

Note: Each of the three payers generate separate RAs for the claims, adjustment requests, or other financial transactions submitted to the payer. A provider who submits claims, adjustment requests, or other financial transactions to more than one of these payers may receive several RAs.

The RA is generated per provider certification. Providers who have a single NPI that is used for multiple certifications should be aware that an RA will be generated for each certification, but the same NPI will be reported on each of the RAs.

For instance, a hospital has obtained a single NPI. The hospital has a clinic, a lab, and a pharmacy that are all certified with ForwardHealth. The clinic, the lab, and the pharmacy submit separate claims that indicate the same NPI as the hospital. Separate RAs will be generated for the hospital, the clinic, the lab, and the pharmacy.

Reporting a Lost Check

To report a lost check to ForwardHealth, providers are required to mail or fax a letter to ForwardHealth Financial Services. Providers are required to include the following information in the letter:

- Provider's name and address, including the ZIP+4 code.
- Provider's identification number.
  - For healthcare providers, include the NPI and ForwardHealth-issued taxonomy code.
  - For non-healthcare providers, include the provider identification number.
- Check number, check date, and check amount. (This should be recorded on the RA.)
- A written request to stop payment and reissue the check.
- The signature of an authorized financial representative. (An individual provider is considered his or her own authorized financial representative.)

Fax the letter to ForwardHealth at (608) 221-4567 or mail it to the following address:

ForwardHealth
Financial Services
6406 Bridge Rd
Madison WI 53784-0005

Searching for and Viewing All Claims on the Portal

All claims, including pharmacy and dental, will be available for viewing on the Portal.

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

- Go to the ForwardHealth 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.

Sections of the Remittance Advice

The RA includes the following sections:

- Address page.
- Banner messages.
- Paper check, if applicable.
- Claims processing information.
- EOB code descriptions.
- Financial transactions.
- Service code descriptions.
- Summary.

Remittance Advice Header Information

The first page of each section of the RA (except the address page) displays the same RA header information.

The following fields are on the left-hand side of the header:

- The technical name of the RA section (e.g., CRA-TRAN-R), which is an internal ForwardHealth designation.
- The RA number, which is a unique number assigned to each RA that is generated.
- The name of the payer (Medicaid, WCDP, or WWWP).
- The "Pay to" address of the provider. The "Pay to" address is used for mailing purposes.

The following information is in the middle of the header:

- A description of the financial cycle.
- The name of the RA section (e.g., "Financial Transactions" or "Professional Services Claims Paid").

The right-hand side of the header reports the following information:

- The date of the financial cycle during which the RA was generated.
- The page number.
- The "Payee ID" of the provider. A payee ID is defined as the identification number of a unique entity receiving payment for goods and/or services from ForwardHealth. The payee ID is up to 15 characters long and may be based on a pre-existing identification number, such as the Medicaid provider number. The payee ID is an internal ForwardHealth designation. The Medicaid provider number will display in this field for providers who do not have an NPI.
- The NPI of the provider, if applicable. This field will be blank for those providers who do not have an NPI.
- The number of the check issued for the RA, if applicable. The date of payment on the check, if applicable.

Verifying Accuracy of Claims Processing

After obtaining ForwardHealth remittance information, providers should compare it to the claims or adjustment requests to verify that ForwardHealth processed elements of the claims or adjustment requests as submitted. To ensure correct reimbursement, providers should do the following:

- Identify and correct any discrepancy that affected the way a claim processed.
- Correct and resubmit claims that are denied.
- Submit an adjustment request for allowed claims that require a change or correction.

When posting a payment or denial to a member's account, providers should note the date on the ForwardHealth remittance information that indicates that the claim or adjustment has finalized. Providers are required to supply this information if further follow-up actions are necessary.

Responsibilities

Accuracy of Claims

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

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

A provider may not seek reimbursement from ForwardHealth 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.

Copayment Amounts

Copayment amounts collected from members should not be deducted from the charges submitted on claims. Providers should indicate their usual and customary charges for all services provided.

In addition, copayment amounts should not be included when indicating the amount paid by other health insurance sources.

The appropriate copayment amount is automatically deducted from allowed payments. Remittance information reflects the automatic deduction of applicable copayment amounts.

Exceptions to the Submission Deadline

State and federal laws provide eight exceptions to the submission deadline. According to federal regulations and DHS 106.03, Wis. Admin. Code, ForwardHealth may consider exceptions to the submission deadline only in the following circumstances:

- Change in a nursing home resident's level of care or liability amount.
- Decision made by a court order, fair hearing, or the DHS.
- Denial due to discrepancy between the member's enrollment information in ForwardHealth interChange and the member's actual enrollment.
- Reconsideration or recoupment.
- Retroactive enrollment for persons on GR.
- Medicare denial occurs after ForwardHealth's submission deadline.
- Refund request from an other health insurance source.
- Retroactive member enrollment.

ForwardHealth has no authority to approve any other exceptions to the submission deadline.

Claims or adjustment requests that meet one of the exceptions to the submission deadline may be submitted to Timely Filing.

Submission Deadline

ForwardHealth recommends that providers submit claims at least on a monthly basis. Billing on a monthly basis allows the maximum time available for filing and refiling before the mandatory submission deadline.

With few exceptions, state and federal laws require that providers submit correctly completed claims before the submission deadline.

Providers are responsible for resolving claims. Members are not responsible for resolving claims. To resolve claims before the submission deadline, ForwardHealth encourages providers to use all available resources.

Claims

To receive reimbursement, claims and adjustment requests must be received within 365 days of the DOS. This deadline applies to claims, corrected claims, and adjustments to claims.

Crossover Claims

To receive reimbursement for services that are allowed by Medicare, claims and adjustment requests for coinsurance, copayment, and deductible must be received within 365 days of the DOS or within 90 days of the Medicare processing date, whichever is later. This deadline applies to all claims, corrected claims, and adjustments to claims. Providers should submit these claims through normal processing channels (not timely filing).

Usual and Customary Charges

For most services, providers are required to indicate their usual and customary charge when submitting claims. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to the program's benefits. For providers using a sliding fee scale, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-program patients. For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost for providing the service.

Providers may not discriminate against BadgerCare Plus or Medicaid members by charging a higher fee for the same service than that charged to a private-pay patient.

For services requiring a member copayment, providers should still indicate their usual and customary charge. The copayment amount collected from the member should not be deducted from the charge submitted. When applicable, BadgerCare Plus automatically deducts the copayment amount.

For most services, BadgerCare Plus reimburses the lesser of the provider's usual and customary charge or the maximum allowable fee established.

Submission

Attached Documentation

Providers should not submit additional documentation with a claim *unless* specifically requested.

Billing Across Midnight

Providers are required to bill for each DOS that care was provided. If a nurse provides care for a member across midnight, *the nurse is required to split the billing over two DOS since the shift extends over two dates*. This means that two modifiers must be used, one for the hours of the shift occurring before midnight, and another to designate the hours of the shift occurring after midnight on the next calendar day.

For example, if a nurse begins care for a member at 8:00 p.m. on December 1 and ends care at 4:00 a.m. on December 2, the agency should bill for four hours of care on December 1 with modifier "UH" and four hours of care on December 2 with modifier "UJ."

Billing Prior Authorized Services with Non-Prior Authorized Services

Claims for services provided under a PA number may be submitted on the same claim as claims for services not requiring PA. However, an exception applies if a service with the same procedure code is provided outside the grant and expiration dates on the PA and then again between the grant and expiration dates on the PA. These services cannot be submitted on a single claim form or the claim will be denied. Two separate claims must be submitted for services in this situation; one for services provided outside the grant and expiration dates and one for services provided between these dates.

For example, a home health PT visit (procedure code 97799) that counts toward the 30-visit threshold for the calendar year is made to a member on February 3, 2005, and, therefore, does not require PA. Beginning on February 7, 2005, the member has an approved PA to receive home health PT (procedure code 97799) because all of the 30 threshold visits for the calendar year have been used. When the physical therapist makes a visit to provide services on February 10, 2005, the service must be billed on a separate claim form from the February 3, 2005, visit because the February 3, 2005, visit falls outside the PA grant and expiration dates for that procedure code. Billing the two visits on the same claim form would cause the claim to be denied.

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

Providers can view EOB codes and descriptions for any claim submitted to ForwardHealth on the Portal. The EOBs will be useful for providers to determine why a claim did not process successfully, so the provider may correct the error online and resubmit the claim. The EOB will appear on the bottom of the screen and will reference the applicable claim header or detail.

Direct Data Entry of Professional and Institutional Claims on the Portal

Providers can submit professional and institutional claims to ForwardHealth via DDE on the Portal. DDE is an online application that allows providers to submit claims directly to ForwardHealth. DDE is not available for dental or pharmacy claims at this time.

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.
- Admission source.
- Admission type.
- Diagnosis codes.
- Revenue codes.
- Procedure codes.
- Modifiers.

Fields within the claim form will automatically calculate totals for providers, eliminating potential clerical errors.

Electronic Claims Submission

Providers are encouraged to submit claims electronically. Electronic claims submission does the following:

- Adapts to existing systems.
- Allows flexible submission methods.
- Improves cash flow.
- Offers efficient and timely payments.
- Reduces billing and processing errors.
- Reduces clerical effort.

Extraordinary Claims

Extraordinary claims are claims that have been denied by a BadgerCare Plus HMO or SSI HMO and should be submitted to fee-for-service.

HIPAA-Compliant Data Requirements

Procedure Codes

All fields submitted on paper and electronic claims are edited to ensure HIPAA compliance before being processed. Compliant code sets include CPT and HCPCS procedure codes entered into all fields, including those fields that are "Not Required" or "Optional."

If the information in all fields are not valid and recognized by ForwardHealth, the claim will be denied.

Provider Numbers

For health care providers, NPIs are required in all provider number fields on paper claims and 837 transactions, including rendering, billing, referring, prescribing, attending, and "Other" provider fields.

Non-healthcare providers, including personal care providers, SMV providers, blood banks, and CCOs should enter valid provider numbers into fields that require a provider number.

Managed Care Organizations

Claims for services that are covered in a member's state-contracted MCO should be submitted to that MCO.

Noncertified Providers

Claims from noncertified in-state providers must meet additional requirements.

Paper Claim Form Preparation and Data Alignment Requirements

Optical Character Recognition

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

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

Speed and Accuracy of Claims Processing

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

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

Handwritten Claims

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

Use Original Claim Forms

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

Use Laser or Ink Jet Printers

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

Alignment

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

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

The following sample claim forms demonstrate correct and incorrect alignment:

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

Clarity

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

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

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

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

Staples, Correction Liquid, and Correction Tape

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

Additional Diagnosis Codes

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

Anchor Fields

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

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

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

- Form Locator 4 (Type of Bill).

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

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

Paper Claim Submission

Paper claims for all home health services (except for DME, DMS, and enteral nutrition products) must be submitted using the UB-04 paper claim form. Claims for home health services submitted on any other claim form will be denied.

Providers should use the UB-04 claim form instructions for home health services when submitting these claims. Do not attach documentation to the claim unless it is specifically required.

Obtaining the Claim Forms

ForwardHealth does not provide the UB-04 claim form. The forms may be obtained from any federal forms supplier.

Durable Medical Equipment, Disposable Medical Supplies, and Enteral Nutrition Products

Providers submitting paper claims for DME, DMS, and enteral nutrition products are required to use the 1500 Health Insurance Claim Form (dated 08/05). The DME service area, the DMS service area, and the Enteral Nutrition Products service area provide claims submission information, as well as policy and PA information.

Submitting Paper Attachments with Electronic Claims

Providers may submit paper attachments to accompany electronic claims and electronic claim adjustments. Providers should refer to their companion documents for directions on indicating that a paper attachment will be submitted by mail.

Paper attachments that go with electronic claim transactions must be submitted with the Claim Form Attachment Cover Page. Providers are required to indicate an ACN for paper attachment(s) submitted with electronic claims. (The ACN is an alphanumeric entry between 2 and 80 digits assigned by the provider to identify the attachment.) The ACN must be indicated on the cover page so that ForwardHealth can match the paper attachment(s) to the correct electronic claim.

ForwardHealth will hold an electronic claim transaction or a paper attachment(s) for up to 30 calendar days to find a match. If a match cannot be made within 30 days, the claim will be processed without the attachment and will be denied if an attachment is required. When such a claim is denied, both the paper attachment(s) and the electronic claim will need to be resubmitted.

Providers are required to send paper attachments relating to electronic claim transactions to the following address:

ForwardHealth
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

UB-04 (CMS 1450) Claim Form Instructions for Home Health Services

The following sample UB-04 claim forms for home health services are available:

- Home health skilled nursing and home health aid services.
- PDN services including shifts spanning midnight.

- PDN ventilator-dependent member services.
- Home health therapy services.

Use the following claim form completion instructions, not the form locator descriptions printed on the claim form, to avoid claim denial or inaccurate claim payment. Complete all form locators unless otherwise indicated. Do not include attachments unless instructed to do so.

These instructions are for the completion of the UB-04 claim for BadgerCare Plus. For complete billing instructions, refer to the National UB-04 Uniform Billing Manual prepared by the National Uniform Billing Committee (NUBC). The National UB-04 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-04 Uniform Billing Manual by calling (312) 422-3390 or by accessing the NUBC Web site.

BadgerCare Plus members receive a ForwardHealth identification card when initially enrolled in BadgerCare Plus. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on covered services and to obtain the correct spelling of the member's name. Refer to the Online Handbook in the Provider area of the ForwardHealth Portal for more information about verifying enrollment.

Note: Each provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of claims relating to reimbursement for services submitted to ForwardHealth.

Submit completed paper claims to the following address:

ForwardHealth
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784--0410

Form Locator 1 — Provider Name, Address, and Telephone Number
Enter the name of the provider submitting the claim and the practice location address. The minimum requirement is the provider's name, city, state, and ZIP+4 code. The name in Form Locator 1 should correspond with the NPI in Form Locator 56.

Form Locator 2 — Pay-to Name, Address, and ID (not required)

Form Locator 3a — Pat. Cntl # (optional)
Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on BadgerCare Plus remittance information.

Form Locator 3b — Med. Rec. # (optional)
Enter the number assigned to the patient's medical/health record by the provider. This number will appear on BadgerCare Plus remittance information.

Form Locator 4 — Type of Bill
Enter the three-digit type of bill code. Providers of home care services should use one of the following type of bill codes:

- 331 = Inpatient admit through discharge claim.
- 332 = Interim bill — first claim.
- 333 = Interim bill — continuing claim.
- 334 = Interim bill — final claim.

Form Locator 5 — Fed. Tax No.
Data is required in this element for OCR processing. Any information populated by a provider's computer software is acceptable for this element. If computer software does not automatically complete this element, enter information such as the provider's federal tax identification number.

Form Locator 6 — Statement Covers Period (From - Through) (not required)

Form Locator 7 — Unlabeled Field (not required)

Form Locator 8 a-b — Patient Name
Enter the member's last name and first name, separated by a space or comma, in Form Locator 8b. Use Wisconsin's EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the

EVS.

Form Locator 9 a-e — Patient Address
Data is required in this element for OCR processing. Any information populated by a provider's computer software is acceptable data for this element (e.g., "Same"). If computer software does not automatically complete this element, enter information such as the member's last name, first name, and middle initial.

Form Locator 10 — Birthdate
Enter the member's birth date in MMDDCCYY format (e.g., September 25, 1975, would be 09251975).

Form Locator 11 — Sex
Specify that the member is male with a "M" or female with a "F." If a member's sex is unknown, enter "U."

Form Locator 12 — Admission Date (not required)

Form Locator 13 — Admission Hr (not required)

Form Locator 14 — Admission Type (not required)

Form Locator 15 — Admission Src (not required)

Form Locator 16 — DHR (not required)

Form Locator 17 — Stat (not required)

Form Locators 18-28 — Condition Codes (required, if applicable)
If appropriate, enter a code to identify conditions relating to this claim that may affect payer processing. Refer to the UB-04 Uniform Billing Manual for a list of condition codes.

Form Locator 29 — ACDT State (not required)

Form Locator 30 — Unlabeled Field (not required)

Form Locators 31-34 — Occurrence Code and Date (required, if applicable)
If appropriate, enter the code and associated date defining a significant event relating to this claim that may affect payer processing. All dates must be printed in the MMDDYY format. Refer to the UB-04 Billing Manual for more information.

Form Locator 35-36 — Occurrence Span Code (From - Through) (not required)

Form Locator 37 — Unlabeled Field (not required)

Form Locator 38 — Responsible Party Name and Address (not required)

Form Locators 39-41 a-d — Value Code and Amount (not required)

Form Locator 42 — Rev. Cd.
Enter the appropriate four-digit revenue code as defined by the NUBC that identifies a specific accommodation or ancillary service. Refer to home health services publications or the UB-04 Billing Manual for information and codes.

Form Locator 43 — Description
Do not enter any dates in this element.

Form Locator 44 — HCPCS/Rate/HIPPS Code
Enter the appropriate five-digit procedure code, followed by as many as four modifiers. Separate the modifier(s) with commas. Refer to home health agency publications for appropriate modifiers.

Form Locator 45 — Serv. Date
Enter the single "from" DOS in MMDDYY format in this form locator.

Form Locator 46 — Serv. Units
Enter the number of covered accommodations, ancillary units of service, or visits, where appropriate. Bill even hours or half-hour increments rounded to the nearest half-hour. Refer to the Online Handbook for rounding guidelines.

Form Locator 47 — Total Charges (by Accommodation/Ancillary Code Category)
Enter the usual and customary charges pertaining to the related procedure code for the current billing period as entered in Form Locators 43 and 45.

Form Locator 48 — Non-covered Charges (not required)

Form Locator 49 — Unlabeled Field
Enter the "to" DOS in DD format. A range of consecutive dates may be indicated only if the revenue code, the procedure code (and modifiers, if applicable), the service units, and the charge were identical for each date within the range.

Detail Line 23

PAGE ___ OF ___
Enter the current page number in the first blank and the total number of pages in the second blank. This information must be included for both single- and multiple-page claims.

CREATION DATE (not required)

TOTALS
Enter the sum of all charges for the claim in this field. If submitting a multiple-page claim, enter the total charge for the claim (i.e., the sum of all details from all pages of the claim) *only on the last page of the claim*.

Form Locator 50 A-C — Payer Name
Enter all health insurance payers here. Enter "T19" for Medicaid and the name of the commercial health insurance, if applicable. If submitting a multiple-page claim, enter health insurance payers only on the first page of the claim.

Form Locator 51 A-C — Health Plan ID (not required)

Form Locator 52 A-C — Rel. Info (not required)

Form Locator 53 A-C — Asg. Ben. (not required)

Form Locator 54 A-C — Prior Payments (required, if applicable)
Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Form Locator 54 is greater than zero, "OI-P" must be indicated in Form Locator 80.) If the commercial health insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

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

Form Locator 55 A-C — Est. Amount Due (not required)

Form Locator 56 — NPI
Enter the provider's NPI. The NPI in Form Locator 56 should correspond with the name in Form Locator 1.

Form Locator 57 — Other Provider ID (not required)

Form Locator 58 A-C — Insured's Name
Data is required in this element for OCR processing. Any information populated by a provider's computer software is acceptable data for this element (e.g., "Same"). If computer software does not automatically complete this element, enter information such as the member's last name, first name, and middle initial.

Form Locator 59 A-C — P. Rel (not required)

Form Locator 60 A-C — Insured's Unique ID
Enter the member's identification number. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct

member ID.

Form Locator 61 A-C — Group Name (not required)

Form Locator 62 A-C — Insurance Group No. (not required)

Form Locator 63 A-C — Treatment Authorization Codes (not required)

Form Locator 64 A-C — Document Control Number (not required)

Form Locator 65 A-C — Employer Name (not required)

Form Locator 66 — Dx (not required)

Form Locator 67 — Prin. Diag. Cd.
Enter the valid, most specific ICD-9-CM code (up to five digits) describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). Do not enter manifestation codes as the principal diagnosis; code the underlying disease first. The principal diagnosis may not include "E" (etiology) codes.

Form Locators 67A-Q — Other Diag. Codes
Enter valid, most specific ICD-9-CM diagnosis codes (up to five digits) corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and that have an effect on the treatment received or the length of stay. Diagnoses that relate to an earlier episode and have no bearing on this episode are to be excluded. Providers should prioritize diagnosis codes as relevant to this claim.

Form Locator 68 — Unlabeled Field (not required)

Form Locator 69 — Admit Dx (not required)

Form Locator 70 — Patient Reason Dx (not required)

Form Locator 71 — PPS Code (not required)

Form Locator 72 — ECI (not required)

Form Locator 73 — Unlabeled Field (not required)

Form Locator 74 — Principal Procedure Code and Date (not required)

Form Locator 74a-e — Other Procedure Code and Date (not required)

Form Locator 75 — Unlabeled Field (not required)

Form Locator 76 — Attending
To indicate the attending provider, enter the attending provider's NPI. In addition, include the last and first name of the attending provider.

Form Locator 77 — Operating (not required)

Form Locators 78 and 79 — Other (not required)

Form Locator 80 — Remarks (enter information when applicable)

Commercial Health Insurance Billing Information
Commercial health insurance coverage must be billed prior to billing ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth.

When the member has dental ("DEN"), Medicare Cost ("MCC"), Medicare + Choice ("MPC") insurance only, or has no commercial health insurance, do not indicate an OI explanation code in Form Locator 80.

When the member has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"),

Medicare Supplement ("SUP"), TriCare ("CHA"), vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial health insurance, *and* the service requires commercial health insurance billing, then one of the following three OI explanation codes *must* be indicated in Form Locator 80. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Form Locator 54 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the member has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to the following: • The member denied coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • The member's commercial health insurance failed to respond to initial and follow-up claims. • Benefits are not assignable or cannot get assignment. • Benefits are exhausted.

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

Medicare Information

Use Form Locator 80 for Medicare information. Submit claims to Medicare before billing ForwardHealth.

Do not indicate a Medicare disclaimer code when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- ForwardHealth indicates the member does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the member does not have Medicare Part A.
- ForwardHealth indicates the provider is not Medicare certified.

  Note: Home health agencies, medical equipment vendors, pharmacies, and physician services providers must be Medicare certified to perform Medicare-covered services for dual eligibles.

- Medicare has allowed the charges. In this case, attach Medicare remittance information, but do not indicate on the claim form the amount Medicare paid.

If none of the above is true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate.

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, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances. *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 certified for 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 the service is not payable due to benefits being exhausted. *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 certified for 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 the service is not payable due to benefits being exhausted.
M-8	Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances. *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 certified for Medicare Part A. • The member is eligible for Medicare Part A. • The service is usually covered by Medicare Part A but not in this circumstance (e.g., member's diagnosis). *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 certified for Medicare Part B. • The member is eligible for Medicare Part B. • The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis).

Form Locator 81 a-d — CC

If the billing provider's NPI was indicated in Form Locator 56, enter the qualifier "B3" in the first field to the right of the form locator, followed by the 10-digit provider taxonomy code in the second field.

Timely Filing Appeals Requests

Requirements

When a claim or adjustment request meets one of the exceptions to the submission deadline, the provider may submit a Timely Filing Appeals Request form. The Timely Filing Appeals Request form may be submitted with either a paper claim or an electronic claim.

DOS that are beyond the submission deadline should be submitted separately from DOS that are within the deadline. Claims or adjustment requests received that contain both current and late DOS are processed through normal channels without review by Timely Filing. Late DOS will be denied.

Resubmission

Decisions on Timely Filing Appeals Requests cannot be appealed. Providers may resubmit the claim to Timely Filing if both of the following occur:

- The provider submits additional documentation as requested.
- ForwardHealth receives the documentation before the specified deadline for the exception to the submission deadline.

Submission

To receive consideration for an exception to the submission deadline, providers are required to submit the following:

- A properly completed Timely Filing Appeals Request form.
- A legible claim or adjustment request.
- All required documentation as specified for the exception to the submission deadline.

To receive consideration, a Timely Filing Appeals Request must be received before the deadline specified for the exception to the submission deadline.

When completing the claim or adjustment request, providers are required to indicate the procedure code, diagnosis code, POS code, etc., as effective for the DOS. However, providers should use the current claim form and instructions or adjustment request form and instructions. Reimbursement for Timely Filing Appeals Requests is contingent upon the claim or adjustment request meeting program requirements for the DOS.

The following table lists the filing deadlines and documentation requirements as they correspond to each of the eight allowable exceptions.

Change in Nursing Home Resident's Level of Care or Liability Amount		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a nursing home claim is initially received within the submission deadline and reimbursed incorrectly due to a change in the member's authorized level of care or liability amount.	To receive consideration, the request must be submitted within 455 days from the DOS and the correct liability amount or level of care must be indicated on the Adjustment/Reconsideration Request form. The most recent claim number (also known as the ICN) must be indicated on the Adjustment/Reconsideration Request form. This number may be the result of a ForwardHealth-initiated adjustment.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050
Decision Made by a Court, Fair Hearing, or the Department of Health Services		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a decision is made by a court, fair hearing, or the DHS.	To receive consideration, the request must be submitted within 90 days from the date of the decision of the hearing. A complete copy of the notice received from the court, fair hearing, or DHS must be	ForwardHealth Timely Filing Ste 50

	submitted with the request.	6406 Bridge Rd Madison WI 53784-0050

Denial Due to Discrepancy Between the Member's Enrollment Information in ForwardHealth interChange and the Member's Actual Enrollment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a claim is initially received by the deadline but is denied due to a discrepancy between the member's enrollment information in ForwardHealth interChange and the member's actual enrollment.	To receive consideration, the following documentation must be submitted within 455 days from the DOS: • A copy of remittance information showing the claim was submitted in a timely manner and denied with a qualifying enrollment-related explanation. • A photocopy of one of the following indicating enrollment on the DOS: ○ White paper BadgerCare Plus EE for pregnant women or children identification card. ○ Green paper temporary identification card. ○ White paper PE for the FPW identification card. ○ The response received through the EVS from a commercial eligibility vendor. ○ The transaction log number received through WiCall.	ForwardHealth Good Faith/Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

ForwardHealth Reconsideration or Recoupment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when ForwardHealth reconsiders a previously processed claim. ForwardHealth will initiate an adjustment on a previously paid claim.	If a subsequent provider submission is required, the request must be submitted within 90 days from the date of the RA message. A copy of the RA message that shows the ForwardHealth-initiated adjustment must be submitted with the request.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Retroactive Enrollment for Persons on General Relief		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when the local county or tribal agency requests a return of a GR payment from the provider because a member has become retroactively enrolled for Wisconsin Medicaid or BadgerCare Plus.	To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the member's enrollment information. The request must be submitted with one of the following: • "GR retroactive enrollment" indicated on the claim. • A copy of the letter received from the local county or tribal agency.	ForwardHealth GR Retro Eligibility Ste 50 6406 Bridge Rd Madison WI 53784-0050

Medicare Denial Occurs After the Submission Deadline		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when claims submitted to Medicare (within 365 days of the DOS) are denied by Medicare after the 365-day submission deadline. A waiver of the	To receive consideration, the following must be submitted within 90 days of the Medicare processing date: • A copy of the Medicare remittance information.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd

submission deadline will not be granted when Medicare denies a claim for one of the following reasons: • The charges were previously submitted to Medicare. • The member name and identification number do not match. • The services were previously denied by Medicare. • The provider retroactively applied for Medicare enrollment and did not become enrolled.	• The appropriate Medicare disclaimer code must be indicated on the claim.	Madison WI 53784-0050

Refund Request from an Other Health Insurance Source		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when an other health insurance source reviews a previously paid claim and determines that reimbursement was inappropriate.	To receive consideration, the following documentation must be submitted within 90 days from the date of recoupment notification: • A copy of the commercial health insurance remittance information. • A copy of the remittance information showing recoupment for crossover claims when Medicare is recouping payment.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Retroactive Member Enrollment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a claim cannot be submitted within the submission deadline due to a delay in the determination of a member's retroactive enrollment.	To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the member's enrollment information. In addition, "retroactive enrollment" must be indicated on the claim.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Coordination of Benefits

3

Archive Date:07/01/2009

Coordination of Benefits:Commercial Health Insurance

Assignment of Insurance Benefits

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

Commercial health insurance companies may permit reimbursement to the provider or member. Providers should verify whether commercial health insurance benefits may be assigned to the provider. As indicated by the commercial 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 commercial health insurance.

If the member is assigned insurance benefits, it is appropriate to submit a claim to ForwardHealth without billing the commercial health insurance. In this instance providers should indicate the appropriate other insurance indicator. ForwardHealth will bill the commercial health insurance.

Claims for Services Denied by Commercial Health Insurance

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

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.

Commercial Managed Care

A commercial managed care plan provides coverage through a specified group of providers in a particular service area. The providers may be under contract with the commercial health insurance and receive payment based on the number of patients seen (i.e., capitation payment).

Commercial managed care plans require members to use a designated network of providers. Non-network providers (i.e., providers who do not have a contract with the member's commercial managed care plan) will be reimbursed by the commercial managed care 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 managed care plan, members enrolled in both a commercial managed care plan and BadgerCare Plus (i.e., state-contracted MCO, fee-for-service) are required to receive services from providers affiliated with the commercial managed care plan. In this situation, providers are required to refer the members to commercial managed care providers. This is necessary because commercial health insurance is always primary to BadgerCare Plus.

BadgerCare Plus will *not* reimburse the provider if the commercial managed care plan denied or would deny payment because a service otherwise covered under the commercial managed care plan was performed by a provider outside the plan. In addition, if a member receives a covered service outside his or her commercial managed care plan, the provider cannot collect payment from the member.

Definition of Commercial Health Insurance

Commericial 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.

Discounted Rates

Providers of services that are discounted by commercial health insurance should include the following on claims submitted:

- Their usual and customary charge.
- The appropriate other insurance indicator.
- The amount, if any, actually received from commercial health insurance as the amount paid by commercial health insurance.

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 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 completed Other Coverage Discrepancy Report 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 he or she believes that benefits are available. Reimbursement from commercial health insurance may be greater than the BadgerCare Plus-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. The provider may not bill BadgerCare Plus and commercial health insurance simultaneously. Simultaneous billing may constitute fraud and interferes with BadgerCare Plus'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. If the commercial health insurance reimburses the member, the provider may collect the payment from the member. If the provider receives reimbursement from BadgerCare Plus and the member, the provider is required to return the lesser amount to BadgerCare Plus.
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. Commercial remittance information should not be attached to the claim.

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, BadgerCare Plus will pay for services covered by both BadgerCare Plus 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 "OI-Y" on paper claims.
- Refer to the Wisconsin Provider Electronic Solutions Manual or the appropriate 837 companion document to determine the appropriate other insurance indicator for electronic claims.

Non-Reimbursable Commercial Managed Care Services

Providers are not reimbursed for the following:

- Services covered by a commercial managed care plan, except for coinsurance, copayment, or deductible.
- Services for which providers contract with a commercial managed care plan to receive a capitation payment for services.

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. Providers are required to use these indicators as applicable on claims 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.

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

- Wisconsin's EVS indicates no commercial health insurance for the DOS.
- The service does not require other health insurance billing.
- Claim denials from other payers relating to NPI 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 DHS 106.02(9)(a), Wis. Admin. Code.

Services Not Requiring Commercial Health Insurance Billing

Providers are not required to bill commercial health insurance sources before submitting claims for the following:

- Case management services.
- Family planning services.
- PNCC services.
- Preventive pediatric services.
- SMV services.

Services Requiring Commercial Health Insurance Billing

If the EVS indicates the code **"DEN"** for "Other Coverage," the provider is required to bill dental services to commercial health insurance before submitting claims to ForwardHealth.

If the EVS indicates that the member has Wausau Health Protection Plan (**"HPP"**), BlueCross & BlueShield (**"BLU"**), Wisconsin Physicians Service (**"WPS"**), TriCare (**"CHA"**), or some other (**"OTH"**) 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.
- Blood bank services.
- Chiropractic services.
- CSP services.
- Dental services.
- DME (rental or purchase), prosthetics, and hearing aids if the billed amount is over $10.00 per item.
- Home health services (excluding PC 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.
- Mental health/substance abuse services, including services delivered by providers other than physicians, regardless of POS.
- PT, OT, and SLP 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 services for ventilator-dependent members.
- Radiology services.
- RHC services.
- Skilled nursing home care, if any DOS is within 30 days of the date of admission. If benefits greater than 30 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 the EVS indicates the code **"VIS"** for "Other Coverage", the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- Ophthalmology services.
- Optometrist services.

If the EVS indicates the code **"HMO"** for "Other Coverage," 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.
- Blood bank services.
- Chiropractic services.
- CSP services.
- Dental services.
- DME (rental or purchase), prosthetics, and hearing aids if the billed amount is over $10.00 per item.
- Home health services (excluding PC services).
- Hospice services.
- Hospital services, including inpatient or outpatient regardless of the type of hospital.
- Independent nurse, nurse practitioner, or nurse midwife services.
- Laboratory services.
- Medicare-covered services billed for a member who has both Medicare and commercial health insurance.
- Mental health/substance abuse services, including services delivered by providers other than physicians, regardless of POS.
- Pharmacy services for members with verified drug coverage.
- PT, OT, and SLP services, unless provided in a nursing home or SNF.
- Physician and physician assistant services.
- Podiatry services.
- PDN services for ventilator-dependent members.
- Radiology services.
- RHC services.
- Skilled nursing home care, if any DOS is within 30 days of the date of admission. If benefits greater than 30 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 the EVS indicates Medicare Supplemental Plan Coverage (**"SUP"**), 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 service 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.

BadgerCare Plus has identified services requiring Medicare billing.

Medicare

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 member is required to accept assignment of the member's Medicare Part B benefits. Therefore, total payment for the service (i.e., any amount paid by other health insurance sources, any copayment or spenddown amounts paid by the member, and any amount paid by Wisconsin Medicaid) may not exceed the Medicare-allowed amount.

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.

Claims Processed by Commercial Insurance That Is Secondary to Medicare

If a crossover claim is also processed by commercial health insurance that is secondary to Medicare (e.g., 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.

Claims That Do Not Require Medicare Billing

For services provided to dual eligibles, 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.

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. Claims with an NPI 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 designated by ForwardHealth is required to identify the billing provider and 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 RA after 30 days of the Medicare processing date, providers are required to resubmit the

claim directly to ForwardHealth using the NPI that was reported to ForwardHealth as the primary NPI. Additionally, the taxonomy code designated by ForwardHealth and the ZIP+4 code of the practice location on file with ForwardHealth are required when an additional date is needed to identify the provider.

Claims for Services Denied by Medicare

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

Coverage Determination Software

CDS helps home health and personal care providers identify when they should bill Medicare before billing Wisconsin Medicaid for dual entitlees. Agencies are required to use the CDS for members who are dual eligibles. Providers are required to use the CDS as follows:

- Use the CDS before the agency provides Medicaid services.
- Use the CDS when a member's condition or status changes, potentially making the member eligible for Medicare coverage.
- Keep a printed copy of the results of the software's determination on file and on the agency's premises for audit purposes.

It is important to use CDS when one agency is sharing a case with another agency. If skilled care is provided by another agency, the member may be eligible for Medicare home health care through that agency. In that situation, a Medicare-certified provider is required to bill Medicare for those services covered by Medicare.

Medicaid Is Payer of Last Resort

Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. Federal law prohibits home health and personal care services that are covered by Medicare to be paid by Medicaid. The CMS accepts the CDS-printed results as documentation that Medicaid is the payer of last resort. If an agency submits claims to Wisconsin Medicaid for services that Medicare pays home health agencies to provide, Wisconsin Medicaid will audit and recoup Medicaid payments.

Although the CDS does not ask questions about a member's other insurance coverage, providers are required to exhaust all existing other health insurance sources before submitting claims to Wisconsin Medicaid.

Personal Care-Only Agencies

Even though agencies certified to provide only personal care cannot bill Medicare, they are required to still use CDS. Wisconsin Medicaid will not reimburse for personal care services which would be reimbursed by Medicare. Personal care-only agencies are not Medicare-enrolled providers. Therefore, these agencies are required to notify all personal care members about Medicare coverage and do the following:

- Provide the member with the Notice to Wisconsin Medicaid Recipients Regarding This Personal Care Agency form.
- Have the member or legally responsible person review and sign the form.
- Give the member a copy and keep the original form in the member's file.

If the member is eligible for Medicare home health services, and the agency is not certified to provide home health services, the provider is required to do one of the following:

- Coordinate care with a Medicare-certified home health agency so that the agency provides only those personal-care hours that exceed Medicare's home health coverage.
- Discharge the member.

Crossover Claims

A Medicare crossover claim is a Medicare-allowed claim for a dual eligible or QMB-Only member sent to ForwardHealth for payment of

coinsurance, copayment, and deductible.

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

- Medicare Part A fiscal intermediary.
- Medicare Part B carrier.
- Medicare DME regional carrier.
- Medicare Advantage 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.

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.

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 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 is enrolled in Medicare and commercial health insurance that is secondary to Medicare (e.g., 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 determined enrolled in BadgerCare Plus.
- The claim is for a member who is enrolled in a Medicare Advantage Plan.

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.
- Taxonomy code that is required by ForwardHealth.
- 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 through the ForwardHealth Provider Portal.
- 837I transaction, as applicable.
- 837P transaction, as applicable.
- PES software.
- Paper claim form.

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. Medicare is a federal government program created under Title XVIII of the Social Security Act.

Medicare coverage is divided into four parts:

- Part A (i.e., Hospital Insurance). Part A helps to pay for medically necessary services, including inpatient hospital services, services provided in critical access hospitals (i.e., 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 (i.e., 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 services, OT services, and some home health services).
- Part C (i.e., Medicare Advantage).
- Part D (i.e., drug benefit).

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, copayment, and deductible for Medicare-allowed services.
- BadgerCare Plus-covered services, even those that are not allowed by Medicare.

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 form, the provider should attach a copy of Medicare remittance information. (If this is a Medicare reconsideration, copies of the original and subsequent Medicare remittance information should be attached.)

Provider-Submitted Crossover Claim

The provider may submit a provider-submitted crossover claim in the following situations:
 	
• The claim is for a member who is enrolled in a Medicare Advantage Plan.
• 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 Medicare and commercial health insurance that is secondary to Medicare (e.g., 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, the provider is required to the do the following:
  ○ Attach Medicare's remittance information and refrain from indicating the Medicare payment.
  ○ Indicate "MMC" in the upper right corner of the claim for services provided to members enrolled in a Medicare Advantage Plan.
 	
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.

* 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 form. 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, 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. 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 occured: • 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 BadgerCare Plus's procedures for submitting crossover claims.

Medicare Advantage

Medicare services may be provided to dual eligibles or QMB-Only members on a fee-for-service basis or through a Medicare Advantage Plan. Medicare Advantage was formerly known as Medicare Managed Care (MMC), Medicare + Choice (MPC), or Medicare Cost (Cost). Medicare Advantage Plans have a special arrangement with the federal CMS 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.

Paper Crossover Claims

Providers are required to indicate "MMC" in the upper right corner of provider-submitted crossover claims for services provided to members enrolled in a Medicare Advantage Plan. The claim must be submitted with a copy of the Medicare EOMB. This is necessary in order for ForwardHealth to distinguish whether the claim has been processed as commercial managed care or Medicare managed care.

Reimbursement Limits

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

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 Wisconsin Medicaid constitutes fraud.

Medicare disclaimer codes identify the status and availability of Medicare benefits. The code allows a provider to be reimbursed correctly by Wisconsin Medicaid 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.

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 DHS 106.02(9)(a), Wis. Admin. Code.

Medicare 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 DHS 106.03(6) and 106.03(7)(b), Wis. Admin. Code, a provider is required to be enrolled in Medicare if both of the following are true:

- He or she provides a Medicare Part B service to a dual eligible.
- He or she 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 certified provider who is enrolled in Medicare.

To receive Medicaid reimbursement for a Medicare Part B service provided to a dual eligible, a provider who is not enrolled in Medicare but can be is required to apply for retroactive enrollment.

Services for Qualified Medicare Beneficiary-Only Members

Because QMB-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 certified provider who is enrolled in Medicare.

Medicare Retroactive Eligibility

If a member becomes retroactively eligible for Medicare, the provider is required to refund or adjust any Medicaid 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.

National Provider Identifier and Related Data on Crossover Claims

An NPI and related data are required on crossover claims, in most instances. However, in some cases the taxonomy code designated by ForwardHealth may not be indicated on automatic crossover claims received from Medicare.

Secondary NPI

Medicare requires that certain subparts of an organization obtain separate NPIs and use the NPI for billing Medicare (e.g., hospital psychiatric unit). If an organization has identified subparts for the purpose of submitting claims to Medicare, and the NPIs appear on automatic crossover claims to ForwardHealth, ForwardHealth considers the NPIs submitted to Medicare to be secondary NPIs. ForwardHealth will process automatic crossover claims using secondary NPIs in cases where the provider has reported a secondary NPI to ForwardHealth. Along with the NPI, providers should also indicate the taxonomy and ZIP+4 code information.

Taxonomy Code Designated by ForwardHealth

The taxonomy code indicated on automatic crossover claims received from Medicare may be different than the taxonomy designated by ForwardHealth. Providers should resubmit the claim to ForwardHealth when the taxonomy code designated by ForwardHealth is required to

identify the provider and is not indicated on the crossover claim received from Medicare.

Qualified Medicare Beneficiary-Only Members

QMB-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, copayment, 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.

Reimbursement for Crossover Claims

Professional Crossover Claims

State law limits reimbursement for coinsurance and copayment of Medicare Part B services provided to dual eligibles and QMB-Only members.

Total payment for a Medicare Part B service (i.e., any amount paid by other health insurance sources, any copayment 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 copayment of a Medicare Part B service is the lesser of the following:

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

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

Reimbursement for Coinsurance or Copayment of Medicare Part B Services			
Explanation	**Example**		
	1	**2**	**3**
Provider's billed amount	$120	$120	$120
Medicare-allowed amount	$100	$100	$100
Medicaid-allowed amount (e.g., maximum allowable fee, rate-per-visit)	$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.

Providers may use the following steps to determine how reimbursement was calculated:

1. Sum all of the detail Medicare paid amounts to establish the Claim Medicare paid amount.
2. Sum all of the detail Medicare coinsurance or copayment amounts to establish the Claim Medicare coinsurance or copayment amount.
3. Multiply the number of DOS by the provider's rate-per-visit. For example, $100 (rate-per-visit) x 3 (DOS) = $300. This is the Medicaid gross allowed amount.
4. Compare the Medicaid gross allowed amount calculated in step 3 to the Claim Medicare paid amount calculated in step 1. If the Medicaid

gross allowed amount is less than or equal to the Medicare paid amount, Wisconsin Medicaid will make no further payment to the provider for the claim. If the Medicaid gross allowed amount is greater than the Medicare paid amount, the difference establishes the Medicaid net allowed amount.

5. Compare the Medicaid net allowed amount calculated in step 4 and the Medicare coinsurance or copayment amount calculated in step 2. Wisconsin Medicaid reimburses the lower of the two amounts.

Services Requiring Medicare Billing

If the EVS indicates Medicare + Choice (**"MPC"**) for "Medicare Managed Care Coverage," the provider is required to bill the following services to the Medicare Advantage Plan before submitting claims to ForwardHealth:

- Ambulance services.
- Ambulatory service center 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.

If the EVS indicates Medicare Cost (**"MCC"**) for "Medicare Managed Care Coverage," the provider is required to bill the following services to the Medicare Advantage Plan before submitting claims to ForwardHealth:

- Ambulance services.
- Home health services (excluding PC services).
- Medicare-covered services.

ForwardHealth has identified services requiring commercial health insurance billing.

Other Coverage Information

After Reporting Discrepancies

After receiving an Other Coverage Discrepancy Report, 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 that the member's other coverage information has been updated.
- The provider receives a written explanation.

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.

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.

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 Other Coverage Discrepancy Report 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.

Reporting Discrepancies

Providers are encouraged to report discrepancies to ForwardHealth by submitting the Other Coverage Discrepancy Report 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.
- 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 (e.g., the member does not live in the plan's service area).

Providers should not use the Other Coverage Discrepancy Report form to update any information regarding a member's coverage in a state-contracted MCO.

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.

Provider-Based Billing

Purpose of Provider-Based Billing

The purpose of provider-based billing is to reduce costs by ensuring that providers receive maximum reimbursement from other health insurance sources that are primary to BadgerCare Plus. For example, a provider-based billing claim is created when BadgerCare Plus pays a claim and later discovers that other coverage exists or was made retroactive. Since BadgerCare Plus benefits are secondary to those provided by most other health insurance sources, providers are required to seek reimbursement from the primary payer, as stated in DHS 106.03(7), Wis. Admin. Code.

Questions About Provider-Based Billing

For questions about provider-based billing claims that are within the 120-day limit, providers may call the Coordination of Benefits Unit at (608) 221-4746. Providers may fax the corresponding Provider-Based Billing Summary to (608) 221-4567 at the time of the telephone call.

For questions about provider-based billing claims that are *not* within the 120-day limit, providers may call Provider Services.

Receiving Notification

When a provider-based billing claim is created, the provider will receive the following:

- A notification letter.
- A Provider-Based Billing Summary. The Summary lists each claim from which a provider-based billing claim was created. The summary also indicates the corresponding primary payer for each claim.
- Provider-based billing claim(s). For each claim indicated on the Provider-Based Billing Summary, the provider will receive a prepared provider-based billing claim. This claim may be used to bill the other health insurance source; the claim includes all of the other health insurance source's information that is available.

If a member has coverage through multiple other health insurance sources, the provider may receive additional Provider-Based Billing Summaries and provider-based billing claims for each other health insurance source that is on file.

Responding to ForwardHealth After 120 Days

If a response is not received within 120 days, the amount originally paid by BadgerCare Plus will be withheld from future payments. This is not a final action. To receive payment after the original payment has been withheld, providers are required to submit the required documentation to the appropriate address as indicated in the following tables. For DOS that are within claims submission deadlines, providers should refer to the first table. For DOS that are beyond claims submission deadlines, providers should refer to the second table.

Within Claims Submission Deadlines		
Scenario	**Documentation Requirement**	**Submission Address**
The provider discovers through the EVS that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.	A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim).	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The provider discovers that the member's other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	• An Other Coverage Discrepancy Report form. • A claim according to normal claims submission procedures after verifying that the member's other coverage information has been updated by using the EVS (do *not* use the prepared provider-based billing claim).	Send the Other Coverage Discrepancy Report form to the address indicated on the form. Send the claim to the following address: ForwardHealth Claims and Adjustments

		6406 Bridge Rd Madison WI 53784-0002
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator. • The amount received from the other health insurance source.	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The other health insurance source denies the provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator or Medicare disclaimer code.	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The commercial health insurance carrier does not respond to an initial *and* follow-up provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator.	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002

Beyond Claims Submission Deadlines		
Scenario	**Documentation Requirement**	**Submission Address**
The provider discovers through the EVS that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.	• A claim (do *not* use the prepared provider-based billing claim). • A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

The provider discovers that the member's other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	• An Other Coverage Discrepancy Report form.
	• *After* using the EVS to verify that the member's other coverage information has been updated, include both of the following:
	  ○ A claim (do *not* use the prepared provider-based billing claim.)
	  ○ A Timely Filing Appeals Request form according to normal timely filing appeals procedures.
		Send the Other Coverage Discrepancy Report form to the address indicated on the form.
		
		Send the timely filing appeals request to the following address:
		
		ForwardHealth
		Timely Filing
		Ste 50
		6406 Bridge Rd
		Madison WI 53784-0050

The commercial health insurance carrier reimburses or partially reimburses the provider-based billing claim.	• A claim (do *not* use the prepared provider-based billing claim). • Indicate the appropriate other insurance indicator. • Indicate the amount received from the commercial insurance. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050
The other health insurance source denies the provider-based billing claim.	• A claim (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator or Medicare disclaimer code. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures. • The Provider-Based Billing Summary. • Documentation of the denial, including any of the following:	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

	○ Remittance information from the other health insurance source. ○ A written statement from the other health insurance source identifying the reason for denial. ○ A letter from the other health insurance source indicating a policy termination date that proves that the other health insurance source paid the member. ○ A copy of the insurance card or other documentation from the other health insurance source that indicates that the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage only. • The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.	
The commercial health insurance carrier does not respond to an initial and follow-up provider-based billing claim.	• A claim (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Responding to ForwardHealth Within 120 Days

Within 120 days of the date on the Provider-Based Billing Summary, the Provider-Based Billing Unit must receive documentation verifying that one of the following occurred:

- The provider discovers through the EVS that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.
- The provider verifies that the member's other coverage information reported by ForwardHealth is invalid.
- The other health insurance source reimbursed or partially reimbursed the provider-based billing claim.
- The other health insurance source denied the provider-based billing claim.
- The other health insurance source failed to respond to an initial *and* follow-up provider-based billing claim.

When responding to ForwardHealth within 120 days, providers are required to submit the required documentation to the appropriate address as indicated in the following table. If the provider's response to ForwardHealth does not include all of the required documentation, the information will be returned to the provider. The provider is required to send the complete information within the original 120-day limit.

Scenario	Documentation Requirement	Submission Address
The provider discovers through the EVS that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.	• The Provider-Based Billing Summary. • Indication that the EVS no longer reports the member's other coverage.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The provider discovers that the member's other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	• The Provider-Based Billing Summary. • One of the following: ○ The name of the person with whom the provider spoke and the member's correct other coverage information. ○ A printed page from an enrollment Web site containing the member's correct other coverage information.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	• The Provider-Based Billing Summary. • A copy of the remittance information received from the other health insurance source.	ForwardHealth Provider-Based Billing PO Box 6220

	• The DOS, other health insurance source, billed amount, and procedure code indicated on the other insurer's remittance information must match the information on the Provider-Based Billing Summary. *Note:* In this situation, ForwardHealth will initiate an adjustment if the amount of the other health insurance payment does not exceed the allowed amount (even though an adjustment request should not be submitted). However, providers (except nursing home and hospital providers) may issue a cash refund. Providers who choose this option should include a refund check but should not use the Claim Refund form.	Madison WI 53716-0220 Fax (608) 221-4567

The other health insurance source denies the provider-based billing claim.	• The Provider-Based Billing Summary.
	• Documentation of the denial, including any of the following:
	  ○ Remittance information from the other health insurance source.
	  ○ A letter from the other health insurance source indicating a policy termination date that precedes the DOS.
	  ○ Documentation indicating that the other health insurance source paid the member.
	  ○ A copy of the insurance card or other documentation from the other health insurance source that indicates the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage.
	• The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.
		ForwardHealth
		Provider-Based Billing
		PO Box 6220
		Madison WI 53716-0220
		Fax (608) 221-4567

The other health insurance source fails to respond to the initial *and* follow-up provider-based billing claim.	• The Provider-Based Billing Summary. • Indication that no response was received by the other health insurance source. • Indication of the dates that the initial and follow-up provider-based billing claims were submitted to the other health insurance source.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567

Submitting Provider-Based Billing Claims

For each provider-based billing claim, the provider is required to send a claim to the appropriate other health insurance source. The provider may use the claim prepared by ForwardHealth or produce his or her own claim. If the other health insurance source requires information beyond what is indicated on the prepared claim, the provider should add that information to the claim. The providers should also attach additional documentation (e.g., Medicare's remittance information) if required by the other health insurance source.

Reimbursement for Services Provided for Accident Victims

Billing Options

Providers may choose to seek payment from either of the following:

- Civil liabilities (e.g., injuries from an automobile accident).
- Worker's compensation.

However, as stated in DHS 106.03(8), Wis. Admin. Code, BadgerCare Plus will not reimburse providers if they receive payment from either of these sources.

The provider may choose a different option for each DOS. For example, the decision to submit one claim to ForwardHealth does not mean that all claims pertaining to the member's accident must be submitted to ForwardHealth.

Points of Consideration

Providers should consider the time and costs involved when choosing whether to submit a claim to ForwardHealth or seek payment from a settlement.

Time

Providers are not required to seek payment from worker's compensation or civil liabilities, rather than seeking reimbursement from BadgerCare Plus, because of the time involved to settle these cases. While some worker's compensation cases and certain civil liability cases may be settled quickly, others may take several years before settlement is reached.

Costs

Providers may receive more than the allowed amount from the settlement; however, in some cases the settlement may not be enough to cover all costs involved.

Seeking Payment from Settlement

After choosing to seek payment from a settlement, the provider may *instead* submit the claim to ForwardHealth as long as it is submitted before the claims submission deadline. For example, the provider may instead choose to submit the claim to ForwardHealth because no reimbursement was received from the liability settlement or because a settlement has not yet been reached.

Submitting Claims to ForwardHealth

If the provider chooses to submit a claim to ForwardHealth, he or she may not seek further payment for that claim in any liability settlement that may follow. Once a claim is submitted to ForwardHealth, the provider may not decide to seek reimbursement for that claim in a liability settlement. Refunding payment and then seeking payment from a settlement may constitute a felony. If a settlement occurs, ForwardHealth retains the sole right to recover medical costs.

Providers are required to indicate when services are provided to an accident victim on claims submitted to ForwardHealth. If the member has other health insurance coverage, the provider is required to exhaust the other health insurance sources before submitting the claim to ForwardHealth.

Covered and Noncovered Services

4

Archive Date:07/01/2009

Covered and Noncovered Services:Codes

Diagnosis Codes

All diagnosis codes indicated on claims (and PA requests when applicable) must be the most specific ICD-9-CM diagnosis code. Providers are responsible for keeping current with diagnosis code changes. Etiology and manifestation codes may not be used as a primary diagnosis.

The required use of valid diagnosis codes includes the use of the most specific diagnosis code. Valid, most specific diagnosis codes may have up to five digits. Claims submitted with three- or four-digit codes where four- and five-digit codes are available may be denied.

All diagnosis codes indicated on claims (and PA requests when applicable) must be from the ICD-9-CM coding structure. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. Providers are responsible for submitting PA requests and claims using the most current diagnosis codes. Claims submitted using out-dated or incorrect codes will be returned to the provider.

All claims for services provided to ventilator-dependent members must list ICD-9-CM code V46.11 (Dependence on respirator, status) as the primary diagnosis code on the claim form. Wisconsin Medicaid will not reimburse claims for respiratory services without this code.

Home health services claims that do not include services provided to a ventilator-dependent member do not require a specific diagnosis code.

Modifiers

Home health providers are required to use nationally recognized modifiers with procedure codes on PA requests and claims forms. No more than four modifiers can be entered for each day on the claim form.

Start-of-Shift Modifiers

Providers are required to use state-defined start-of-shift modifiers on claims. Start-of-shift modifiers are not required on PA requests.

Providers should choose the start-of-shift modifier that most closely represents the time each shift began. For each day, enter the modifiers in the order of occurrence. If a single shift spans over midnight from one day to the next, providers are required to use two start-of-shift modifiers.

Professional Status Modifiers

Home health agencies that provide PDN services to ventilator-dependent members are required to use one of two nationally recognized modifiers to indicate a nurse's professional status. Professional status modifiers are required on PA requests and claims.

Place of Service

When submitting PA requests, providers are required to include a POS code. Providers should choose the most appropriate POS when requesting PA. The following table lists examples of nationally recognized, two-digit POS codes.

Code	Description
03	School
12	Home
99	Other Place of Service

Prior Authorization Number

Each PA request is assigned a unique ten-digit number. When the POC is updated at times other than requesting PA, including the PA number on the POC is optional. Including the PA number on a POC that is not being submitted with a PA request is optional. However, Wisconsin Medicaid recommends that providers include the PA number on the POC even when it is optional. A PA number has record keeping advantages for the

nurses on the case and will make the POC easier to reference in the future.

Procedure Code and Modifier Table

The following table lists the HCPCS and CPT procedure codes providers should use when submitting claims and PA requests. The table also lists the nationally recognized modifiers that apply to each procedure code.

Procedure Code and Description (Limited to Medicaid Covered Service)	National Modifier	State-Defined Start-of-Shift Modifier
90656 — Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use	None	None
90658 — Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use	None	None
90732 — Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use	None	None
92507 — Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual [per visit]	None	**UJ —** Night (12 a.m. to 5:59 a.m.) **UF —** Morning (6 a.m. to 11:59 a.m.) **UG —** Afternoon (12 p.m. to 5:59 p.m.) **UH —** Evening (6 p.m. to 11:59 p.m.)
97139 — Unlisted therapeutic procedure (specify) [per visit]	None	**UJ —** Night (12 a.m. to 5:59 a.m.) **UF —** Morning (6 a.m. to 11:59 a.m.) **UG —** Afternoon (12 p.m. to 5:59 p.m.) **UH —** Evening (6 p.m. to 11:59 p.m.)
97799 — Unlisted physical medicine/rehabilitation service or procedure [per visit]	None	**UJ —** Night (12 a.m. to 5:59 a.m.) **UF —** Morning (6 a.m. to 11:59 a.m.) **UG —** Afternoon (12 p.m. to 5:59 p.m.) **UH —** Evening (6 p.m. to 11:59 p.m.)
99504 — Home visit for mechanical ventilation care [per hour]	**TE —** LPN/LVN	**UJ —** Night (12 a.m. to 5:59 a.m.) **UF —** Morning (6 a.m. to 11:59 a.m.) **UG —** Afternoon (12 p.m. to 5:59 p.m.) **UH —** Evening (6 p.m. to 11:59 p.m.)
99504 — Home visit for mechanical ventilation care [per hour]	**TD —** RN	**UJ —** Night (12 a.m. to 5:59 a.m.) **UF —** Morning (6 a.m. to 11:59 a.m.) **UG —** Afternoon (12 p.m. to 5:59 p.m.) **UH —** Evening (6 p.m. to 11:59 p.m.)
99600 — Unlisted home visit service or procedure [per visit]	None	**UJ —** Night (12 a.m. to 5:59 a.m.) **UF —** Morning (6 a.m. to 11:59 a.m.) **UG —** Afternoon (12 p.m. to 5:59 p.m.) **UH —** Evening (6 p.m. to 11:59 p.m.)
99600 — Unlisted home visit service or procedure [per visit]	**TS —** Follow-up service	**UJ —** Night (12 a.m. to 5:59 a.m.) **UF —** Morning (6 a.m. to 11:59 a.m.) **UG —** Afternoon (12 p.m. to 5:59 p.m.) **UH —** Evening (6 p.m. to 11:59 p.m.)
S9123 — Nursing care, in the home; by registered nurse, per hour	None	**UJ —** Night (12 a.m. to 5:59 a.m.) **UF —** Morning (6 a.m. to 11:59 a.m.) **UG —** Afternoon (12 p.m. to 5:59 p.m.) **UH —** Evening (6 p.m. to 11:59 p.m.)
S9124 — Nursing care, in the home; by licensed practical nurse, per hour	None	**UJ —** Night (12 a.m. to 5:59 a.m.) **UF —** Morning (6 a.m. to 11:59 a.m.) **UG —** Afternoon (12 p.m. to 5:59 p.m.)

		UH — Evening (6 p.m. to 11:59 p.m.)
T1001 — Nursing assessment/evaluation [per visit]	None	**UJ** — Night (12 a.m. to 5:59 a.m.) **UF** — Morning (6 a.m. to 11:59 a.m.) **UG** — Afternoon (12 p.m. to 5:59 p.m.) **UH** — Evening (6 p.m. to 11:59 p.m.)
T1021 — Home health aide or certified nurse assistant, per visit	None	**UJ** — Night (12 a.m. to 5:59 a.m.) **UF** — Morning (6 a.m. to 11:59 a.m.) **UG** — Afternoon (12 p.m. to 5:59 p.m.) **UH** — Evening (6 p.m. to 11:59 p.m.)
T1021 — Home health aide or certified nurse assistant, per visit	**TS** — Follow-up service	**UJ** — Night (12 a.m. to 5:59 a.m.) **UF** — Morning (6 a.m. to 11:59 a.m.) **UG** — Afternoon (12 p.m. to 5:59 p.m.) **UH** — Evening (6 p.m. to 11:59 p.m.)
T1502 — Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit	None	**UJ** — Night (12 a.m. to 5:59 a.m.) **UF** — Morning (6 a.m. to 11:59 a.m.) **UG** — Afternoon (12 p.m. to 5:59 p.m.) **UH** — Evening (6 p.m. to 11:59 p.m.)

Procedure Codes

When submitting PA requests and claims, home health providers should use HCPCS procedure codes. Providers should refer to the DME Index for a list of valid procedure codes for DME. Providers should refer to the DMS Index for a list of valid procedure codes for DMS.

Home health agencies providing services to ventilator-dependent members should use CPT procedure codes on PA requests and claims.

Revenue Codes

Providers are required to use a revenue code when submitting claims to ForwardHealth. The following table contains a list of revenue code examples. Providers should use the appropriate revenue code that best describes the service performed.

For the most current and complete list of revenue codes, contact the AHA NUBC by calling (312) 422-3390 or writing to the following address:

American Hospital Association National Uniform Billing Committee
29th Fl
1 N Franklin
Chicago IL 60606

For further information, refer to the NUBC Web site.

Revenue Code	Service Description
0550	General Skilled Nursing
0551	Skilled Nursing Visit
0552	Skilled Nursing Hourly Charge
0580	Other Home Health Services, Except Therapies
0420	Physical Therapy
0430	Occupational Therapy
0440	Speech and Language Pathology

Units of Service

The number of services (visits or hours) billed must be listed on each detail line of the claim form.

Home health aide visits, home health skilled nursing visits, and home health therapy visits are billed as one unit of service per day. If the quantity billed is not an increment of a whole unit, the service is denied.

PDN services are rounded and billed in half-hour increments. The rounding guidelines for PDN services are as follows:

- If the visit ends in an increment between one and 30 minutes in length, the provider should round the time to 30 minutes and bill the service as a quantity of .5.
- If the visit ends in an increment over 30 minutes in length, the provider should round up or down to the nearest 30-minute increment, using the common rules of rounding listed in the following table.

Accumulated Time	Unit(s) Billed
1-30 minutes	0.5
31-44 minutes	0.5
45-60 minutes	1.0
61-74 minutes	1.0
75-90 minutes	1.5
91-104 minutes	1.5
105-120 minutes	2.0
121-134 minutes	2.0
Etc.	

Covered Services and Requirements

An Overview of Covered Home Health Services

The following services are covered when provided by home health agencies:

- Home health skilled nursing services.
- Home health aide services.
- PDN services (for BadgerCare Plus Standard Plan and Medicaid members only).
- Home health therapy services.
- DME.
- DMS.
- Personal care services (for Standard Plan and Medicaid members only).

Benchmark Plan Covered Home Care Services

Home care services covered under the BadgerCare Plus Benchmark Plan are the same as those covered under the BadgerCare Plus Standard Plan except for the following:

- PDN services.
- Personal care services.

Service Limitations

Under the Benchmark Plan, home care services are limited to 60 home health visits per member per enrollment year.

Benchmark Plan Enrollment Year

Under the BadgerCare Plus Benchmark Plan, an enrollment year is defined as the continuous 12-month period beginning the first day of the calendar month in which a member is enrolled in the Benchmark Plan and ending on the last day of the 12th calendar month.

For example, a member completes her BadgerCare Plus application materials by September 25, 2008. During the month of October, the DHS reviews the application materials and determines that the member is eligible for the Benchmark Plan effective September 1, 2008, the first day of the calendar month that the application materials were completed; however, the enrollment year for this member will not begin until October 1, 2008, the first day of the calendar month in which the DHS actively enrolled the member in the Benchmark Plan. The Benchmark Plan enrollment year for this member is defined as October 1, 2008, through September 30, 2009. Services received after eligibility is established and before the enrollment year begins are covered under the Benchmark Plan but do not count toward the service limitations.

Subsequent enrollment years begin on the first day of the calendar month immediately following the end of the previous enrollment year, if there is no coverage gap. If there is a coverage gap for more than one day, the enrollment year will reset to begin on the first day of the month in which the DHS re-enrolls the member into the Benchmark Plan.

If a member switches from the Benchmark Plan to the BadgerCare Plus Standard Plan, the Benchmark Plan enrollment year does not reset. For example, a member's enrollment year under the Benchmark Plan begins March 1, 2008. During the third month, the member's income status changes and she is now eligible for the Standard Plan effective June 1, 2008. During August, the DHS determines that the member is no longer eligible for the Standard Plan and effective September 1, 2008, the member returns to the Benchmark Plan. Since there is not a gap in coverage, the initial Benchmark Plan enrollment year is still active. The member must adhere to limits for services received while covered under the Benchmark Plan during the enrollment year period March 1, 2008, through February 28, 2009.

The Benchmark Plan enrollment year is the time period used to determine service limitations for members in the Benchmark Plan. Services received while covered under the Standard Plan do not count toward the enrollment year service limitations in the Benchmark Plan and vice versa. If a member switches between the two plans during one enrollment year, service limitations will accumulate separately under each plan.

Case Sharing

If more than one type of Medicaid-certified home care provider provides care to a member, the case becomes a shared case. All home health agencies sharing a case with other home health agencies, personal care agencies, or NIPs should document their communication with the other providers regarding member needs, POC, and scheduling. This will ensure coordination of services and continuity of care, while also preventing duplication of services being provided to a member.

According to DHS 101.03(96m)(b)(6), Wis. Admin. Code, medically necessary services cannot be duplicative with respect to other services being provided to the member. When providers of more than one service type share a case, home health agencies need to integrate that information into the member's POC and the PA request.

Daylight Savings Time

Wisconsin Medicaid reimburses only for the number of hours actually worked. Providers who work when daylight savings time ends are still required to adhere to the limitations on authorized services. Authorization is limited to 12 hours in each 24-hour period and 60 hours in a calendar week for any one nurse. Nurses are expected to adjust their schedules in advance to accommodate changes in the clock time.

Definition of Covered Services

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

Disposable Medical Supplies Included in the Home Care Reimbursement Rate

DMS are medically necessary items that have a limited life expectancy and are consumable, expendable, disposable, or nondurable.

The cost of routine DMS used by home health providers, personal care providers, and NIP while caring for the member, including routine DMS mandated by OSHA, is covered in the reimbursement rate for the service provided. Home health providers, personal care providers, and NIP are expected to provide these supplies only during the billable hours in which they provide covered services. Providers are not expected to provide members with supplies for use when they are not directly providing covered services.

Note: None of the DMS covered in the reimbursement rate are separately reimbursable.

When DMS is included in the reimbursement rate, providers may *not* do any of the following:

- Charge the member for the cost of DMS.
- Use supplies obtained by the member and paid for by Wisconsin Medicaid.
- Submit claims to ForwardHealth for the cost of the supplies.

DMS included in the home care reimbursement rate include, but are not limited to, those listed in the following table.

Procedure Code	Modifier	Description
A4244	-	Alcohol or peroxide, per pint
A4365	-	Adhesive remover wipes, any type, per 50 (Ostomy use only)
A4402	-	Lubricant per ounce
A4455	-	Adhesive remover or solvent (for tape, cement or other adhesive), per ounce
A4554	-	Disposable underpads, all sizes [when used for purposes *other than* incontinence or bowel and bladder programs]
A4626	59	Applicators
A4626	22	Cotton balls per 100
A4927	-	Gloves, non-sterile, per 100

The December 2002 *Wisconsin Medicaid and BadgerCare Recipient Update*, titled "Your home care provider is required to supply some disposable medical supplies used for your care," explains this policy to members who receive home care services. Providers are encouraged to share this information with new members.

Durable Medical Equipment

DME is equipment that can withstand repeated use, is primarily used for medical purposes, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home.

DME is covered only when prescribed by a physician. Covered services are limited to items contained in the DME Index. Some items require PA. For further information, refer to the DME service area.

Emergencies

Certain program requirements and reimbursement procedures are modified in emergency situations. Emergency services are defined in DHS 101.03(52), Wis. Admin. Code, as "those services that are necessary to prevent the death or serious impairment of the health of the individual." Emergency services are not reimbursed unless they are covered services.

Additional definitions and procedures for emergencies exist in other situations, such as dental and mental health.

Program requirements and reimbursement procedures may be modified in the following ways:

- PA or other program requirements may be waived in emergency situations.
- Noncertified providers may be reimbursed for emergency services.
- Non-U.S. citizens may be eligible for covered services in emergency situations.

Limits on Authorized Services

The nurse providing PDN and/or PDN-Vent members may not provide nursing service in excess of 12 hours in a calendar day and 60 hours in a calendar week to all members and other patients under the nurse's care, as stated DHS 107.113(5)(d), and 107.12(4)(f) and 107.12(4)(g), Wis. Admin. Code.

The nurse is also required to take at least eight continuous and uninteruppted hours off duty in any 24-hour period during which he or she performs PDN and/or PDN-Vent services that are reimbursed by Wisconsin Medicaid, as stated in DHS 107.12(4)(g) and 107.113(5)(g) Wis. Admin. Code.

PDN and/or PDN-Vent services provided in excess of the calendar day and calendar week limits are not covered. Services provided when the nurse does not meet the off-duty requirements are also considered non-covered services.

Definitions for for a Calendar Day and a Calendar Week

The following definitions are applicable to PDN and to PDN-Vent.

- A 24-hour period should not be confused with a calendar day. For the purpose of Wisconsin Medicaid PDN services, each calendar day is a 24-hour period that begins at midnight and ends at midnight.
- A calendar week begins with Sunday, ends with Saturday, and consists of seven consecutive calendar days.
- A 24-hour period consists of 24 consecutive hours and should not be confused with a calendar day.

*Note:*Exemptions to these rules may exist in extremely rare circumstances. Requests for exceptions should be made in writing to:

ForwardHealth Home Care Analyst
Division of Health Care Access and Accountability
Rm 350
1 West Wilson St
Madison WI 53702

Medical Necessity

Wisconsin Medicaid reimburses certified home health agencies for medically necessary home health services as defined by DHS 101.03(96m), Wis. Admin. Code, provided to eligible members when prescribed by a physician. All services are required to be medically necessary and appropriate to the diagnosis and medical condition of the member. Wisconsin Medicaid may deny or recoup payment if a service fails to meet Medicaid medical necessity requirements.

Member Payment for Covered Services

Under state and federal laws, a Medicaid-certified provider may not collect payment from a member, or authorized person acting on behalf of the member, for covered services even if the services are covered but do not meet program requirements. Denial of a claim by does not necessarily render a member liable. However, a covered service for which PA was denied is treated as a noncovered service. (If a member chooses to receive an originally requested service instead of the service approved on a modified PA request, it is also treated as a noncovered service.) If a member requests a covered service for which PA was denied (or modified), the provider may collect payment from the member if certain conditions are met.

If a provider collects payment from a member, or an authorized person acting on behalf of the member, for a covered service, the provider may be subject to program sanctions including termination of Medicaid certification.

Place of Residence

Home health services are covered by Wisconsin Medicaid only when they are performed at the member's place of residence.

A member's home or residence is considered to be the place where the member makes his or her home. The member's residence may be a single family home or an apartment unit. The member may reside with other household members. Hospital inpatient and nursing facilities are not allowable places of service while the member is receiving home health services.

The residence may be a CBRF; however, home health services may not exceed the limits established in chapter DHS 83, Wis. Admin. Code, and may not duplicate services that the CBRF is being paid to provide.

The following home health services are covered for members when the services are medically necessary and the member requires a considerable and taxing effort to leave the residence or cannot reasonably obtain these services outside the residence:

- Home health skilled nursing.
- PT.
- OT.
- SLP.

A member may receive PDN services and home health aide services from a home health agency without any limitations on his or her homebound status. However, home health aide services must be provided only in the member's place of residence.

Program Requirements

For a covered service to meet program requirements, the service must be provided by a qualified Medicaid-certified provider to an enrolled member. In addition, the service must meet all applicable program requirements, including, but not limited to, medical necessity, PA, claims submission, prescription, and documentation requirements.

Services Provided by Nurses in Independent Practice

Federal and state laws permit Wisconsin Medicaid to pay for home health skilled nursing services provided by an NIP *only* when no home health agency is available. An NIP is required to have PA before providing home health services to a member.

The following conditions *must* be met before an NIP can submit claims to ForwardHealth for home health services:

- No home health agency is willing and able to provide care to the member. If an NIP submits claims to ForwardHealth, that nurse is required to submit documentation supporting this condition with the PA request. The NIP, the member, the member's family, or a discharge planner is first required to try to locate services by contacting *all* home health agencies serving the member's area. Documentation must include the following:
  - The name of each home health agency contacted.
  - The name of the person contacted at the home health agency.
  - The date and time of contact.
  - Information the caller provided to the home health agency contact.
  - A list of the questions the caller asked the home health agency contact.
  - The responses the home health agency contact gave to the caller's questions.
- The services must be medically necessary.
- Member requires a considerable and taxing effort to leave the residence or the member cannot reasonably obtain these services outside the residence or from a more appropriate provider.
- All rules in DHS 101-109, Wis. Admin. Code, must be followed. Home health services provided by an NIP are monitored after payment has been made. Payment for services that do not follow these guidelines will be recouped.

Services That Do Not Meet Program Requirements

As stated in DHS 107.02(2), Wis. Admin. Code, BadgerCare Plus may deny or recoup payment for covered services that fail to meet program requirements.

Examples of covered services that do not meet program requirements include the following:

- Services for which records or other documentation were not prepared or maintained.
- Services for which the provider fails to meet any or all of the requirements of DHS 106.03, Wis.Admin. Code, including, but not limited to, the requirements regarding timely submission of claims.
- Services that fail to comply with requirements or state and federal statutes, rules, and regulations.
- Services that the DHS, the PRO review process, or BadgerCare Plus determines to be inappropriate, in excess of accepted standards of reasonableness or less costly alternative services, or of excessive frequency or duration.
- Services provided by a provider who fails or refuses to meet and maintain any of the certification requirements under DHS 105, Wis. Admin. Code.
- Services provided by a provider who fails or refuses to provide access to records.
- Services provided inconsistent with an intermediate sanction or sanctions imposed by the DHS.

Training Requirements

Home health agency providers will only be reimbursed for covered services provided by agency staff who are properly trained, as indicated by licensure, certification, or other documentation of training in the provider's personnel file.

Universal Precautions

All caregivers providing services are required to follow universal precautions for each member for whom services are provided. It is recommended that all caregivers are required to have the necessary orientation, education, and training in the epidemiology, modes of transmission, and prevention of transmissible infections.

HealthCheck "Other Services"

Definition of HealthCheck "Other Services"

HealthCheck is a federally mandated program known nationally as EPSDT. HealthCheck services consist of a comprehensive health screening of members under 21 years of age. On occasion, a HealthCheck screening may identify the need for health care services that are not otherwise covered by or that exceed coverage limitations. These services are called HealthCheck "Other Services." Federal law requires that these services be reimbursed through HealthCheck "Other Services" if they are medically necessary and prior authorized. The purpose of HealthCheck "Other Services" is to assure that medically necessary medical services are available to BadgerCare Plus Standard Plan and Medicaid members under 21 years of age.

HealthCheck "Other Services" are not available to members enrolled in the BadgerCare Plus Benchmark Plan except for child/adolescent mental health day treatment.

Prior Authorization

To receive PA for HealthCheck "Other Services," providers are required to submit a PA request via the ForwardHealth Portal or to submit the following via fax or mail:

- A completed PA/RF (or PA/DRF, or PA/HIAS1).
  - The provider should mark the checkbox titled "HealthCheck Other Services" at the top of the form.
  - The provider may omit the procedure code if he or she is uncertain what it is. The ForwardHealth consultant will assign one for approved services.
- The appropriate service-specific PA attachment.
- Verification that a comprehensive HealthCheck screening has been provided within 365 days prior to ForwardHealth's receipt of the PA request. The date and provider of the screening must be indicated.
- Necessary supporting documentation.

Providers may call Provider Services for more information about HealthCheck "Other Services" and to determine the appropriate PA attachment.

Requirements

For a service to be reimbursed through HealthCheck "Other Services," the following requirements must be met:

- The condition being treated is identified in a HealthCheck screening that occurred within 365 days of the PA request for the service.
- The service is provided to a member who is under 21 years of age.
- The service may be covered under federal Medicaid law.
- The service is medically necessary and reasonable.
- The service is prior authorized before it is provided.
- Services currently covered are not considered acceptable to treat the identified condition.

BadgerCare Plus has the authority to do all of the following:

- Review the medical necessity of all requests.
- Establish criteria for the provision of such services.
- Determine the amount, duration, and scope of services as long as limitations are reasonable and maintain the preventive intent of the HealthCheck program.

Home Health Aide Services

Active Seizure Intervention

Active seizure intervention, including safety measures, reporting seizures, and administration of medication at the time of the active seizure, may be a delegated nursing act. Active seizure intervention may be medically necessary when the member has had active seizures requiring active intervention within the past 62 days. Active seizure intervention does not include administration of routine anti-seizure medication. When observation for seizures is the only service performed, it is not a Medicaid-reimbursed service.

Activity of Daily Living Tasks

Assistance with the member's ADLs as listed in DHS 107.11(2)(b)2, Wis. Admin. Code, is considered a home health aide service only when provided in conjunction with a delegated nursing act that cannot be safely delegated to a PCW as determined and documented by the delegating RN. ADL tasks are not generally provided to preschool children but may be covered when the tasks require special skills to assure safety or are provided incidental to a delegated nursing act.

Assistance with Activities That Are Directly Supportive of Skilled Therapy Services

Assistance with activities that directly support skilled therapy services include those activities that do not require the skills of a therapy provider to be safely and effectively performed. Activities may include routine maintenance exercises, e.g., range of motion exercises and repetitive speech routines. In order to be medically necessary, the activities must be ordered in conjunction with an active home health therapy program or as the direct result of a therapy evaluation completed and signed by a therapy provider within the past six months.

Complex Feeding

Complex feeding may be a delegated nursing act and medically necessary when there is a potential for aspiration and the physician's orders indicate special feeding precautions or techniques must be utilized to effect safe feeding.

Feeding via a gastrostomy tube may be a delegated nursing act when delegated by the RN after assessment of the member's medical condition and the home health aide's training.

Complex Repositioning

Complex repositioning is positioning to reduce spasticity or to decrease pressure and/or shear forces that can lead to decubitus ulcer formation (i.e., Bolsters/Side-Lyers). Complex repositioning may be medically necessary when the member has a demonstrated problem with frequent skin breakdown.

Complex Transfers

Complex transfers are transfers that require the use of mechanical devices when there is an increased likelihood that a negative outcome would result if the transfer is not done correctly or when a complex transfer technique is used as part of a home health therapy program.

The following transfer techniques are part of the suggested personal care curriculum and *do not qualify as complex transfers*:

- Standing-pivot.
- Sliding board.
- Gait belts.

Complex transfers may be medically necessary when the member has no volitional movement or when simple transfer techniques have been

demonstrated to be ineffective and unsafe.

Definition

Home health aide services are services necessary to maintain the member's health or to facilitate treatment of the member's medical condition. There are three components to the services home health aides may provide in the home:

- Delegated nursing acts.
- ADL tasks.
- Household tasks.

For activities of daily living and/or household tasks incidental to direct care activities to be covered when provided by a home health aide, the home health aide must provide at least one RN-delegated medically oriented task with each home health aide visit (DHS 107.11[2][b], Wis. Admin. Code). When no RN-delegated medically oriented task is to be provided, the activities might be covered as a personal care service. For more information regarding coverage of personal care services, refer to the Personal Care area of the Online Handbook.

Delegated Nursing Acts

Delegated nursing acts are those medically necessary tasks that require some special medical knowledge or skill. Delegated nursing acts are usually reimbursed for minor children. Delegated nursing acts that may be safely delegated by an RN may be reimbursable home health aide services. Delegated nursing acts include, but are not limited to, the following:

- Medication administration.
- Skin care.
- Dressing changes.
- Assistance with activities directly supportive of skilled therapy services.
- Vital signs.
- Glucometer readings.
- Complex transfers.
- Complex repositioning.
- Complex feeding.
- Donning or doffing of a prosthesis or orthosis.
- Active seizure intervention.

Delegation of Tasks

Each home health aide task must be specifically assigned by an RN. The RN must determine that the home health aide is trained to perform each task in a manner that will not jeopardize the member's health. A home health aide may not be assigned to any task for which he or she is not trained.

Note: RNs may only delegate *nursing* acts to a home health aide. A *medical* act that has been delegated to an RN by a physician may not be re-delegated by the RN to any other provider.

In accordance with ch. N 6.03(3), Wis. Admin. Code, an RN should do all of the following in the supervision and direction of delegated nursing acts:

- Delegate tasks commensurate with education preparation and demonstrated abilities of the person supervised.
- Provide direction and assistance to those supervised.
- Observe and monitor the activities of those supervised.
- Evaluate the effectiveness of acts performed under supervision.

Home health agencies must document that these conditions are met when nursing acts are delegated to home health aides.

Donning and Doffing of a Prosthesis or an Orthosis

Donning or doffing of a prosthesis or orthosis may be a delegated nursing act and medically necessary when part of a serial splinting program or when the member has a demonstrated problem with frequent skin breakdown that must be closely monitored.

Dressing Changes

Some dressing changes may not require the skills of a licensed nurse and may be safely performed by a home health aide. Wounds or ulcers that show redness, edema, or induration — at times with epidural blistering or desquamation — do not ordinarily require skilled nursing care. Dressing changes may be medically necessary when the physician orders them for the treatment of a wound or sore, and no primary caregiver is willing or able to provide the care.

Glucometer Readings

Taking glucometer readings and reporting them to the supervising nurse whenever the readings are outside the parameters established for the member by the physician may be medically necessary when the member's medical history supports the need for ongoing monitoring for early detection of readings outside the established parameters. Glucometer readings related to the noncompliance of a competent adult do not justify glucometer tests as medically necessary tasks.

Home Health Aide Visits

Within home health aide services, Wisconsin Medicaid reimburses for only two types of home health visits:

- *Home Health Aide Initial Visit*. The member's first home health aide visit in a calendar day. For BadgerCare Plus and Medicaid purposes, an initial visit may last up to four hours. Only one home health aide initial visit is reimbursable per calendar day per member, regardless of the number of providers.
- *Home Health Aide Subsequent Visit*. Each additional home health aide visit following the initial visit per calendar day. For BadgerCare Plus and Medicaid purposes, a home health aide subsequent visit may last up to three hours.

A visit begins when the home health aide enters the residence to provide a covered service. The visit ends when the home health aide leaves the residence.

Upon completion of the covered service, additional visits per day may be covered only when necessary. Additional visits must only be used to provide medically necessary time-specific tasks, tasks that could not feasibly be provided in one visit, or when the provider obtains PA for continuous visits. Examples of time-specific tasks include:

- Helping the member in and out of bed using a hoyer lift.
- Scheduled G-tube feedings.

Maximizing Visits

The time spent at home health aide visits must be maximized whenever possible before scheduling additional home health aide visits or personal care visits.

All cares that can be fulfilled utilizing the allotted four hours for an initial visit or the allotted three hours for a subsequent visit should be performed during that scheduled visit. Scheduling a subsequent visit or personal care visit later in the same day to complete cares that could have been completed during a previous visit that day would not be considered medically necessary because the previous visit was not maximized.

In addition, when case sharing with a personal care agency, home health aide visits must be maximized whenever possible before a PCW begins providing care. The home health aide should perform all personal cares in addition to the delegated nursing acts during the visit.

Continuous Visits

All home health aide visits in excess of four hours must be prior authorized if the agency wishes to bill for more than one visit. These home health aide visits are referred to as continuous visits. Continuous visits may be medically necessary when there is a likelihood that immediate medical attention will be required at unpredictable intervals due to a member's medical condition. Immediate attention is classified as needing service within five minutes, leaving inadequate time for the member to call in a home health aide. The intervention must include a delegated nursing act.

When continuous visits of four or more hours are medically necessary, providers may bill for more than one visit when the visits have PA. Providers may not bill multiple visits for continuous home health aide visits without PA. Providers are required to request PA for continuous visits regardless of the 30-visit threshold.

Household Tasks

When a home health aide visits a member to provide a delegated nursing act, the home health aide may also perform some household tasks. Provision of household tasks must be incidental to delegated nursing acts and personal care tasks and must not be the primary reason for the home health aide visit.

Household tasks are typically provided by parents for their minor children. Most household tasks provided to minor children are not covered. Incidental household tasks may be reimbursed only when the tasks are incidental to covered delegated nursing acts or covered ADL tasks.

Medication Administration

"Administer" is defined in the Pharmacy Examining Board Act, Chapter 450.01(1), Wis. Stats., as the direct application of a prescription drug or device, whether by injection, ingestion, or any other means, to the body of a patient.

Medication administration may be covered for an adult member when the member is unable to self-administer and there is no willing and able caregiver to administer the medication.

Parents typically administer medications to their minor children. However, medication administration may be reimbursed for minor children when the parents are unable to administer the medication. This includes times when parents are not allowed to leave work to administer medications and no other arrangements can be made.

General Agency Requirements Applicable to All Medication Administration by Home Health Aides

All home health agencies providing administration of a medication by a home health aide must meet the following conditions:

- The agency has policies and procedures designed to provide safe and accurate administration of medication. These policies must be followed by personnel assigned to administer medications (42 CFR s. 484.14[e]). This must include the required documentation of the name of the medication, the dose, the route of administration, the time of administration, and the identification of the person administering the medication.
- There is a written delegation of this nursing act (medication administration) by the RN as specified in DHS 133.17(3), Wis. Admin. Code.
- There is documentation that gives evidence of the educational preparation of the caregiver who administers medications as stated in DHS 133.06(4)(b), Wis. Admin. Code.
- There is immediate and accessible supervisory support available to the caregiver administering medications as directed by DHS 133.18(2), Wis. Admin. Code.
- Members must be informed, prior to delivery of service, that their medications will be administered by unlicensed personnel as stated in DHS 133.08(2)(d), Wis. Admin. Code, and 42 CFR s. 484.10(c)(1).
- Supervision and direction of the delegated nursing act meets the requirements of ch. N 6.03(3), Wis. Admin. Code, which states that in the supervision and direction of delegated nursing acts, an RN shall do the following:
  - Delegate tasks commensurate with educational preparation and demonstrated abilities of the person supervised.
  - Provide direction and assistance to those supervised.
  - Observe and monitor the activities of those supervised.
  - Evaluate the effectiveness of acts performed under supervision.

Administration of Preselected Medication

A home health aide may administer medications to any member, regardless of age or functional capacity, when both of the following conditions are met:

- The medication is preselected by a nurse, pharmacist, member, or designated family member.
- All agency requirements are met.

Administration of Medication That Is Not Preselected

Administration of medication by home health aides may include selection of the medication and selection of the dose, along with direct application of the medication.

The act of administration of medication that has not been preselected may be provided by home health aides only when both of the following conditions are met and documented in the provider's records:

- When medication has not been preselected, there is documented evidence that the home health aide has been trained in the actions, uses, effects, adverse reactions, and toxic effects of all medications administered. Additionally, the home health aide must be trained relative to appropriate responses to adverse reactions to any medication administered. The delegating RN must verify the training by doing at least one return demonstration with each home health aide administering medication to a specific member as directed by DHS 133.06(4)(c), Wis. Admin. Code.
- All agency requirements are met.

Place of Service

Services must be provided in the member's residence to be covered home health aide services.

Providers of Services

Home health aides are required to be trained according to requirements issued by the DQA. The completion of training and demonstration of competency to perform each assigned task should be documented in the home health aide's personnel record.

An RN, a physical therapist, an occupational therapist, or a speech-language pathologist is required to prepare written instructions for member services provided by a home health aide, as appropriate. Instructions may include duties, delegated nursing acts, a home therapy program, assistance with a member's activities of daily living, and household tasks incidental to direct care.

Skin Care

Skin care may be a delegated nursing act and medically necessary when legend solutions, lotions, or ointments are ordered by the physician due to skin breakdown, wounds, open sores, etc. Typically, a legend drug is a medication not sold over-the-counter. PRN or prophylactic skin care is an ADL task, not a delegated nursing act.

Vital Signs

Taking vital signs may include, but is not limited to, taking the following readings from the member:

- Temperature.
- Blood pressure.
- Pulse.
- Pulse oximetry readings.
- Respiratory rate.

The member's vital signs are to be reported to the supervising nurse whenever they are outside the parameters established for the member by the physician. Taking vital signs may be medically necessary when the member's medical history supports the need for ongoing monitoring for early detection of an exacerbation, and the physician establishes parameters at which point a change in treatment may be required.

Home Health Skilled Nursing Services

Catheters

Insertion and sterile irrigation and replacement of indwelling urinary catheters and care of suprapubic catheters are considered skilled nursing services. When the catheter is necessitated by a permanent or temporary loss of bladder control, medically necessary skilled nursing services that are provided at a frequency appropriate to the type of catheter in use are reimbursable.

When complications are absent, Foley catheters generally require skilled service once every 30 days and silicone catheters generally require skilled service once every 60-90 days. More frequent care may be reimbursed if documentation supports the medical necessity. This frequency of service is considered reasonable and medically necessary. In some instances, there are complications that require more frequent skilled services related to the catheter.

If intermittent catheterization is delegated to an LPN or home health aide by the RN, medical record documentation must support that the LPN or home health aide has been taught the procedure and has demonstrated competence in the procedure.

Determining Skilled Nursing Services

In determining whether a service is skilled (i.e., requires the skills of an RN or LPN), providers should consider the inherent complexity of the service, the condition of the member, and accepted standards of medical and nursing practice. Some services are classified as skilled nursing services on the basis of the complexity of the services alone, such as intravenous and intramuscular injections or insertion of catheters. However, the member's condition may be such that a service that would ordinarily be considered unskilled may be considered a skilled nursing service because the service can only be safely and effectively provided by a nurse.

Agencies should be aware that while some services may be provided by a licensed nurse, they may not be considered a Medicaid-covered service. For example, nonskilled services provided by a nurse due to the unavailability of a home health aide or PCW to provide the nonskilled services, regardless of the importance of the services to the member, are not reimbursable as skilled nursing services.

Examples of Circumstances in Which Skilled Nursing May Be Required

There may be circumstances in which skilled nursing services may be required for services that might ordinarily be considered unskilled care. For example:

- A broken leg does not necessarily indicate a need for skilled care. However, if the member has a pre-existing circulatory condition, skilled nursing services may be needed to check for complications, to monitor medication administration for pain control, and to teach proper ambulation techniques to ensure proper bone alignment and healing.
- The condition of a member who has irritable bowel syndrome or who is recovering from rectal surgery may be such that only a nurse can safely and effectively give the member an enema. If the enema is necessary to treat the medical condition, the visit may be covered as a skilled nursing visit.

However, a service that, by its nature, requires the skills of a licensed nurse to be provided safely and effectively, continues to be a skilled service even if it is taught to the member, the member's family, or other caregivers. For example, if a member is discharged from the hospital with an open draining wound that requires irrigation, packing, and dressing twice each day, the care is considered skilled nursing care, even if the family is taught to perform the care and provides it part or all of the time.

Home Health Skilled Nursing Visits

Wisconsin Medicaid reimburses only two types of home health skilled nursing visits:

- *Home Health Skilled Nursing Initial Visit* — the member's first home health skilled nursing visit of any duration by an RN or LPN in a calendar day. Only one initial visit is reimbursable per calendar day per member, regardless of the number of providers.
- *Home Health Skilled Nursing Subsequent Visit* — each additional home health skilled nursing visit of any duration following the initial visit per calendar day.

A visit begins when the RN or LPN enters the residence to provide a covered service. The visit ends when the RN or LPN leaves the residence at the conclusion of the covered service.

A visit made by a skilled nurse solely to train other home health providers is not a covered service. The home health agency is responsible for ensuring that its providers are properly trained to perform any service it furnishes. The cost of a skilled nurse's visit for the purpose of training home health agency staff is an administrative cost to the home health agency.

Intake Evaluations

Federal regulations require home health agencies to have written policies concerning the acceptance of members by the agency. When personnel of the agency make an intake evaluation visit, the cost of the visit is considered an administrative cost of the agency and is not reimbursable separately as a skilled nursing visit since, at this point, the member has not been accepted for care.

If, however, during the course of this intake evaluation visit, the member is determined suitable for home health care by the agency and is also provided the first skilled nursing service as ordered by the POC, the visit would become the first reimbursable home health skilled nursing visit.

Member Enrollment for Services

According to DHS 107.11(2), Wis. Admin. Code, a member is eligible for home health skilled nursing services if he or she:

- Requires less than eight hours of direct, skilled nursing services in a 24-hour period according to the POC.
- Does not reside in a hospital or nursing facility.
- Requires a considerable and taxing effort to leave the residence or cannot reasonably obtain services outside the residence.

Nasopharyngeal and Tracheostomy Suctioning

Nasopharyngeal and tracheostomy suctioning are skilled nursing services and are covered as skilled nursing services if they are required to treat the member's medical condition.

Ostomy Care

Ostomy care during the post-operative period and in the presence of associated complications where the need for skilled nursing care is clearly documented is a skilled nursing service. Teaching of ostomy care is reimbursable during the time that a skilled assessment or another covered skilled nursing care is required.

Place of Service

Services must be provided in the member's place of residence to be covered home health skilled nursing services.

Qualifying Hours of Care

A maximum of 30 calendar days of skilled nursing care may continue to be reimbursed as home health services, beginning on the day 8 hours or more of skilled nursing services became necessary. To continue medically necessary services after 30 days, PA for PDN is required under HFS DHS 107.12(2).

To determine if a member receives less than eight hours of direct skilled nursing services, add up the total hours of direct skilled nursing care provided by all caregivers, including home health agencies, independent nurses, and skilled cares provided by family or friends. If this adds up to *less* than eight hours, the member may enroll for home health skilled nursing services.

If the member requires eight or *more* hours of direct skilled nursing services in a 24-hour period, he or she may enroll for PDN services. A member cannot be enrolled for both home health skilled nursing services and PDN services.

Reimbursable Assessments

Assessment of a member's condition is always a part of required nursing supervision. However, the assessment of the member's condition may be reimbursable as a skilled nursing service when:

- The member's medical condition requires a nurse to identify and evaluate the need for possible modification of treatment. This may include when the following indications are present and documented:
  - Abnormal or fluctuating vital signs.
  - Weight changes.
  - Edema.
  - Symptoms of drug toxicity.
  - Abnormal or fluctuating lab values.
  - Respiratory changes on auscultation.

  A one-time visit by an RN may be medically necessary to assess and evaluate the medical condition of the member in response to a home health aide, PCW, the member or the member's family, or another person expressing concern that the member's medical condition may have changed. This assessment visit may be covered whether or not the visit results in intervention or a change in the POC. Providers may request an amendment to a PA to cover this visit.

  The member's medical condition requires a nurse to initiate additional medical procedures until the member's treatment regimen stabilizes but is not part of an established pattern of care.

  A member often requires a skilled nursing assessment during the first 30 days following hospital discharge or until the member's medical condition and treatment regimen stabilizes.

- There is a likelihood of complications or an acute episode requiring a nurse to identify and evaluate the member's need for possible modification of treatment or initiation of additional medical procedures until the member's treatment regimen is essentially stabilized.

  When a member is admitted to home health care for assessment because there is reasonable potential of a complication or further acute episode, the skilled assessment services are covered only for as long as there remains a reasonable potential for such a complication or acute episode. Medical record documentation must support the likelihood of a future complication or acute episode.

Examples of Reimbursable Assessments

The following are examples of reimbursable assessments:

- A member with arteriosclerotic heart disease with unstable congestive heart failure requires close observation by skilled nursing personnel for signs of decompensation or adverse affects from prescribed medication. Skilled assessment is needed to determine whether the drug regimen should be modified or whether other therapeutic measures should be considered until the member's treatment regimen is essentially stabilized.
- A member has undergone peripheral vascular disease treatment, including a bypass. The incision area is showing signs of potential infection, and the member has an elevated temperature. Skilled assessment of the perfusion of the legs and the integrity of the incision site is necessary until the signs of potential infection have abated.

Reimbursable Ongoing Assessment Visits

When an assessment visit does not meet the guidelines for medical necessity, it may be reimbursed as an ongoing assessment (Title 19 re-evaluation) visit if all of the following criteria are met:

- The member's medical condition is stable (a medical condition is considered stable when the member's physical condition is non-acute and without substantial variability at the current time).
- The member has not received a covered skilled nursing service (including medication management), covered personal care service, or covered home visit by a physician within the past 62 days.
- A skilled assessment is required to re-evaluate the continuing appropriateness of the POC.

In accordance with federal Medicaid regulations, the visit must be ordered by a physician in order to be covered. In the ongoing assessment visit, the RN is required to do the following:

- Assess the member's current medical condition (including systems assessment, environmental assessment, psychosocial assessment, and functional assessment).
- Evaluate the member's progress or lack of progress towards meeting established goals.
- Modify the POC as needed.

The ongoing assessment visit is to be used to assess the member who is only receiving home health aide services or home health aide and home health therapy services. Persons receiving covered skilled nursing visits must be assessed during those covered visits. Skilled nursing services include the following:

- PDN provided by an RN or LPN.
- PDN for ventilator-dependent members provided by an RN or LPN.
- Initial or subsequent home health nursing visits.
- Personal care supervisory visits.

Wisconsin Medicaid may reimburse for ongoing skilled nursing assessments and visits provided once every 55 calendar days.

PA is not required for an ongoing assessment visit. Providers are required to submit claims using the ongoing assessment visit procedure code.

Examples of Non-Reimbursable Ongoing Assessments

The following are examples of non-reimbursable ongoing assessments:

- A physician orders one skilled nursing visit every two weeks and three PCW visits each week for bathing and washing hair for a member whose recovery from a cerebral vascular accident has caused a residual weakness on the left side. The member's condition is stable and the member has reached the maximum functional independence. There are currently no underlying conditions that would necessitate a skilled assessment, therefore, an ongoing assessment visit would not be covered in this situation because a personal care visit is more appropriate.
- A visit that is made specifically for filling out paperwork, such as an OASIS, is not covered.

Reimbursable Teaching and Training Activities

Teaching and training activities that require skilled nursing personnel to teach a member, the member's family, or unpaid caregivers how to manage the treatment regimen would constitute skilled nursing services only when provided to a member in conjunction with other reimbursable skilled nursing services.

When it becomes apparent after a reasonable period of time that the member, family, or caregiver is unwilling or unable to learn or be trained, further teaching and training ceases to be reasonable and medically necessary. The reason that the member, family, or caregiver is unwilling or unable to be trained should be documented in the medical record.

Examples of Reimbursable Teaching and Training Activities

The following are examples of reimbursable teaching and training activities:

- A physician has ordered skilled nursing services for a man who was hospitalized for a broken hip and has now been discharged to home. While hospitalized, the member was newly diagnosed with diabetes. Skilled nursing care is ordered to closely monitor blood glucose levels until the levels stabilize and to assess understanding of and compliance with a diabetic diet. In this case, teaching of self-injection and management of insulin, signs and symptoms of insulin shock, and actions to take in emergencies is reasonable and necessary to the treatment of the medical condition, since the member is receiving skilled care and cannot reasonably be expected to go to his physician for the instruction.
- A member with arteriosclerotic heart disease and congestive heart failure requires close observation by a nurse for signs of decompensation or adverse affects resulting from newly prescribed medication. When visiting the member to assess his or her medical condition, teaching about the medication regimen is appropriate. (Under Wisconsin pharmacy law and Wisconsin Medicaid regulations, pharmacists are required to instruct the person picking up a prescription about the medication, including instructions for administration and signs of adverse reactions. In most cases, the person obtaining the prescription may also obtain this information over the telephone.)

Reimbursable Venipunctures

Venipuncture is a skilled nursing service when the collection of the specimen is necessary to the diagnosis and treatment of the member's medical condition and when the venipuncture cannot be performed in the course of regularly scheduled absences from the home to acquire medical treatment. The frequency of visits for venipuncture must be reasonable within accepted standards of medical practice for treatment of the medical condition. Venipuncture is reasonable and necessary when the following occurs:

- The treatment is recognized as being reasonable and medically necessary to the treatment of the medical condition. The physician order for the venipuncture should clarify the need for the test when it is not diagnosis/illness specific.
- The frequency of the testing is consistent with accepted standards of medical practice for continued monitoring and assessment of a diagnosis, medical problem, or treatment regimen. Even when the laboratory results are consistently stable, periodic venipunctures may be reasonable and necessary because of the nature of the treatment.

Reimbursable Venipuncture for Prothrombin

Venipuncture may be reimbursable when the following is true:

- Documentation shows that the dosage is being adjusted and ongoing monitoring is ordered by the physician.
- The results are stable within non-therapeutic ranges. There must be documentation of other factors that would indicate why continued monitoring is reasonable and medically necessary.
- The results are stable within the therapeutic ranges. Monthly monitoring may be reasonable and necessary.

Examples of Reasonable and Necessary Venipunctures

The following are examples of reasonable and necessary venipuctures:

- Many medications may cause side effects, such as leukopenia and agranulocytosis, and it is standard medical practice to monitor the white blood cell count and differential count on a routine basis (every three months) when the results are stable and the member is asymptomatic.
- In monitoring phenytoin (e.g., Dilantin ®) administration, the difference between a therapeutic and a toxic level of phenytoin in the blood is very slight. It is therefore appropriate to monitor the level on a routine basis (every three months) when the results are stable and the member is asymptomatic.
- A member with coronary artery disease was hospitalized with atrial fibrillation and was subsequently discharged to the home health agency with orders for anticoagulation therapy. Monthly venipunctures as indicated are necessary to report prothrombin (protime) levels to the physician.

Supervision

In accordance with licensure requirements and as stated in ch. N 6, Wis. Admin. Code, LPNs are required to be supervised by an RN or a physician.

Ongoing supervision of a home health aide, LPN, or PCW must be provided in accordance with DHS 105.16(2)(b), Wis. Admin. Code.

Supervisory visits must include:

- A review and evaluation of the member's medical condition and medical needs according to the written POC during the period in which agency care is being provided.
- An evaluation of the appropriateness of the relationship between the direct care giver and the member.
- An assessment of the extent to which the member's goals are being met.
- A determination of whether or not the current level of home health services provided to the member continues to be appropriate to treat the member's medical condition.
- A determination of whether or not the services are medically necessary.
- A discussion and review with the member about the services received by the member.

After each supervisory visit, the RN must discuss the results of the supervisory visits with the home health aide, LPN, or PCW. The results of each supervisory visit must be documented in the member's medical record.

Separate reimbursement for supervisory visits is limited to PCW supervisory visits. Specific information on the supervision of PCWs is available in the Personal Care area of the Online Handbook.

Tube Insertions and Feedings

Nasogastric, gastrostomy, and jejunostomy tube feeding are covered services. Replacement, stabilization, and suctioning of the tubes are also covered skilled nursing services.

If the feeding of a member via gastrostomy or jejunostomy tube is delegated to an LPN, home health aide, or PCW, medical record documentation must support that the caregiver has been instructed in all aspects of tube feeding. This delegation may occur only when deemed appropriate by the supervising RN after assessment of the member's medical condition.

Wound Care

Wound care relates to the direct, hands-on skilled nursing care provided to members with wounds, including any necessary dressing changes on those wounds.

Wound care, including, but not limited to, ulcers, burns, pressure sores, open surgical sites, fistulas, and tube sites, is a skilled nursing service when the skills of a licensed nurse are needed to safely and effectively care for the wound. For skilled nursing care to be reasonable and necessary to treat a wound, the grade, size, depth, nature of drainage (color, odor, consistency, and quantity), condition, and appearance of the surrounding skin of the wound must be documented in the POC. This allows an assessment of the need for skilled nursing to be made.

The POC must contain the specific instructions for the wound treatment. Where the physician has ordered appropriate active treatment (e.g., sterile or complex dressings, administration of prescription medications) of wounds with the following characteristics, the skills of a licensed nurse may be reasonable and necessary:

- Open wounds that are draining purulent exudate or that have a foul odor present and/or for which the member is receiving antibiotic therapy.
- Wounds with a drain or T-tube that require interval position changes.
- Wounds that require irrigation or instillation of a sterile cleansing or medicated solution into several layers of tissue and skin and/or packing with sterile gauze.
- Recently debrided ulcers.
- Pressure sores (decubitus ulcers) that present the following characteristics:
  - Partial tissue loss with signs of infection, such as foul odor or purulent drainage.
  - Full thickness tissue loss that involves exposure of fat or invasion of other tissue, such as muscle or bone.
- Wounds with exposed internal vessels or a mass that may have a proclivity for hemorrhage when a dressing is changed.
- Open wounds or widespread skin complications following radiation therapy or that result from immune deficiencies or vascular insufficiencies.
- Post-operative wounds where there are complications, such as infection or allergic reaction, or there is an underlying disease that has a reasonable potential to adversely affect healing (e.g., diabetes).
- Third degree burns and second degree burns, where the size of the burn or presence of complications causes skilled nursing care to be needed.
- Other open or complex wounds that require treatment that can be safely and effectively provided only by a licensed nurse.

For skilled nursing services to continue, there must be ongoing medical record documentation of the grade, size, depth, nature of drainage, and condition of the wound and appearance of surrounding skin.

Skilled nursing care is ordinarily not required for wounds or ulcers that show redness, edema and induration, at times with epidermal blistering or desquamation. Wounds that only require an antibacterial ointment, nonsterile covering, occlusive covering, opsite or duoderm, and wounds with minimal serous or serosanguinous drainage also do not require skilled nursing care.

However, while the initial care for a wound might not require the services of a skilled nurse, the wound may still require skilled monitoring and assessment for signs and symptoms of infection or complication.

Home Health Therapy Services

Cotreatment

Cotreatment (interdisciplinary treatment) is simultaneous treatment by two providers of different therapy disciplines during the same time period. If a member requires multiple therapies, and each therapy has a unique approach to the member's treatment, the therapies should be separately and independently provided to give the member the maximum benefit and opportunity for rehabilitation. Providers are also required to meet PA requirements for cotreatment.

Definition

As stated in DHS 107.11(2), Wis. Admin. Code, the following types of medically necessary skilled therapy services provided by a home health agency are covered:

- PT.
- OT.
- SLP.

Examples

The following are examples of reimbursable home health therapy visits:

- A member with a diagnosis of multiple sclerosis has recently been discharged from the hospital following an exacerbation of her condition that has left her wheelchair bound and, for the first time, without any expectation of achieving ambulation again. The physician has ordered OT to select the proper wheelchair for her long-term use, to teach the member and her family safe use of the wheelchair and safe transfer techniques in her home. OT would be reasonable and necessary to evaluate the member's overall needs, to make the selection of the proper wheelchair, and to teach the member and/or family safe use of the wheelchair, proper transfer techniques, and other self-care activities.
- A physician prescribes PT treatments three times a week for 45 days for a member who has been discharged from the hospital following a recent hip fracture. The member was discharged using a walker for seven days from the start of home care. The POC shows that the member was discharged from the hospital with restricted mobility in ambulation, transfers, and climbing of stairs. The member has an unsafe gait that indicates a need for gait training, and the member had not been instructed in stair climbing and a home exercise program. The goal of the PT will be to increase strength and range of motion, to progress from walker to cane with safe gait, and to address stair climbing. The services are reasonable and necessary for the treatment of the member's medical condition.

Home Health Therapy Visits

A home heath therapy visit is a visit of any duration by a physical therapist, occupational therapist, or speech-language pathologist for a period of therapy service. Only one PT visit, OT visit, and SLP visit, per member, per day, is reimbursable by Wisconsin Medicaid.

A visit begins when the therapy provider enters the residence to provide a covered service. The visit ends when the therapy provider leaves the residence.

A visit made by a therapy provider solely to train other home health providers is not a covered service. The home health agency is responsible for ensuring that its providers are properly trained to perform any service it furnishes. The cost of a skilled therapy provider's visit for the purpose of training home health agency providers is an administrative cost to the home health agency.

Medically Necessary Skilled Therapy Services

Services that may only be performed safely and effectively by a skilled physical therapist, occupational therapist, or speech-language pathologist are considered skilled therapy services. Wisconsin Medicaid will cover only skilled therapy services that are medically necessary. The skilled therapy services must be consistent with the nature and severity of the member's medical condition and functional

status. The amount, frequency, and duration of the services must also be medically necessary and must not duplicate other services being provided.

The skilled therapy services must be provided with the expectation of *one* of the following outcomes, based on the physician's assessment of the member's rehabilitation potential:

- The condition of the member is expected to improve materially in a reasonable and generally predictable period of time.
- The services are necessary to the establishment of a safe and effective maintenance program.

Also, the member must show the following:

- Motivation, interest, or desire to participate in home health therapy. The frequency and amount of home health therapy should depend on the member's demonstrated response to current therapy and/or estimated response to proposed therapy.
- Progress toward meeting or maintaining established measurable goals or show carryover (follow-through of activities or skills learned) within six months of treatment at home.

The skilled therapy services must be considered, under accepted standards of medical practice, to be specific and effective treatment for the member's condition.

Services of skilled therapy providers that are for the purpose of teaching the member or the member's family or caregivers necessary techniques, exercises, or precautions are covered to the extent that they are reasonable and necessary to treat the medical condition. Direct treatment must be provided during family or caregiver education session(s).

The therapy provider is required to provide a summary of all therapy activities, including goals and outcomes, to the member's physician at least every 62 days, and also upon the completion of therapy services to the member.

Place of Service

BadgerCare Plus and Medicaid therapy services provided through home health agencies must be provided in the member's place of residence except when federal regulations allow services to be provided elsewhere due to the need for special equipment.

Providers of Services

Home health therapy services are provided by physical therapists, occupational therapists, and speech-language pathologists through home health agencies. The therapy providers may be any of the following:

- Employed by the home health agency.
- Employed by an agency under contract with the home health agency.
- Independent providers under contract with the home health agency.

Therapy providers employed by, or under contract with, home health agencies are required to meet all Medicaid certification requirements, but they are not required to be individually certified by Wisconsin Medicaid. The home health agency is required to maintain records showing that its individual providers meet Medicaid requirements.

Supervision of Assistants

A physical therapist, occupational therapist, or speech-language pathologist is required to be physically present at a member's residence to supervise an assistant. The supervising physical therapist, occupational therapist, or speech-language pathologist is required to be of the same therapy discipline as the assistant. The agency may bill for the services of either the physical therapist, occupational therapist, speech-language pathologist, or the assistant during any one visit; the agency may not bill for both professionals at the same time.

Therapy Evaluation

A therapy evaluation must be completed prior to the development of a therapy POC. The evaluation must be reviewed, signed, and dated by the rendering therapy provider, who must be identified as such on the evaluation. The evaluation must include the comprehensive results

of formal/informal tests and measurements that provide a baseline for the member's functional limitations from which a POC is established. The evaluation must include written instructions for follow through or carryover by the member and/or caregiver. Follow through or carryover must be realistically achievable by the member and/or caregiver at the place of residence.

Therapy Plan of Care

A therapy POC must be completed prior to the provision of home health therapy services. The therapy POC must contain specific and measurable goals that are related to an identified deficit and are appropriate to the member's chronological or developmental age, way of life, and home situation. The therapy goals must be medical in nature, rather than educational, social, or vocational.

Medication Management and Administration

Available Alternatives to Medication Management Visits

Several alternatives are available to assist in meeting members' medication needs and should be considered when determining the medical necessity and frequency of medication management visits.

A variety of dispensing devices, adaptive aids, and delivery systems are available to assist a member in dispensing his or her own medication. Examples of these include:

- Insulin pens.
- Medication dispensers.
- Medication organizers.
- Alarms.

Providers should contact the member's physician to determine if prescribing one of these products would be appropriate for the member.

Insulin Pens

For each fill, Wisconsin Medicaid covers up to a 100-day supply of prefilled insulin pens and cartridges through the pharmacy benefit. A pharmacy can submit claims to ForwardHealth for prescriptions for insulin products and supplies.

Combining Services

In consultation with the member's physician, home health agencies should determine the best combination of medication management visits and use of alternative dispensing devices, adaptive aids, and delivery systems appropriate to the member's condition.

Community Vaccination Clinics

Home health agencies may submit claims to ForwardHealth for medically necessary influenza and pneumococcal vaccinations provided at community vaccination clinics. There must be established written protocol, policy, and guidelines that are approved by the agency's medical director.

Providers are required to submit a separate UB-04 claim form using the appropriate procedure code for each member receiving these vaccines. ForwardHealth does not accept rosters of members who received vaccines.

Eye Drops and Topical Ointments

The administration of eye drops and topical ointments does not require the skills of a licensed nurse. Therefore, even if the administration of eye drops or ointments is necessary for the treatment of an illness or injury and the member cannot self-administer them, and there is no one available to administer them, the visits cannot be covered as a skilled nursing service. However, administration can be provided during a covered skilled nursing visit for observation and assessment of the member's condition.

Home Vaccination

Home health agencies may administer the influenza and pneumococcal vaccines to members who they are currently serving when there is a physician order for the vaccination.

A nurse is required to administer the vaccine during an already scheduled home health skilled nursing visit. Wisconsin Medicaid does not reimburse for a home health skilled nursing visit if administration of the vaccination is the only purpose for the visit.

Providers should submit claims for influenza and pneumococcal vaccinations using the UB-04 claim form. When billing for a vaccine,

providers should list both the procedure code appropriate for the type of home health skilled nursing visit (initial or subsequent) and the procedure code for the type of vaccine administered.

Intravenous, Intramuscular, or Subcutaneous Injections and Infusions or Intravenous Feedings

Intravenous, intramuscular, or subcutaneous injections and infusions or intravenous feedings require the skills of a nurse to be performed safely and effectively. The medication being administered must be accepted as safe and effective treatment of the member's medical condition, and there must be a medical reason that the medication cannot be taken orally. With the exception of intravenous medications and infusions, these tasks are reimbursable only as medication management visits.

The frequency and duration of the administration of the medication must be within accepted standards of medical practice, or there must be a valid explanation regarding the extenuating circumstances that justify the need for additional injections.

Insulin Injections

Insulin injections by a nurse are not usually considered skilled nursing services. Insulin is customarily self-injected by members or injected by their families, although assistive devices may sometimes be required. However, the injections would be considered a reasonable and necessary skilled nursing service when a member cannot reasonably obtain services outside the residence, is either physically or mentally unable to self-inject insulin (even with the aid of assistive devices), and there is no other person who is able and willing to inject the member. These services are not covered when a member is eligible for insulin injections and other home health services through Medicare or another insurance provider.

Vitamin B-12 Injections

Vitamin B-12 injections are considered specific therapy only for the following conditions:

- Alcohol neuropathies.
- Anastomosis or partial resection of small intestines.
- Anemia, fish tapeworm.
- Anemia, macrocytic.
- Anemia, megaloblastic.
- Anemia, pernicious.
- Anemia, post-bowel resection.
- Anemia, post-gastrectomy syndrome.
- Blind loop syndrome.
- Cancer of stomach, liver, intestines, and colon.
- Crohn's disease.
- Posterolateral sclerosis.
- Sprue or other malabsorption states.
- Strictures of small intestine.

Synagis® Injections

Synagis® injections are covered only when they are part of an already scheduled, covered skilled nursing visit, and there is a physician's order for the service. Wisconsin Medicaid does not reimburse for skilled nursing visits where the administration of Synagis® is the only purpose for the visit.

Tuberculosis Skin Test

Tuberculosis skin tests and the reading of those tests are covered only when they are part of an already scheduled, covered skilled nursing visit, and there is a physician's order for the service. Wisconsin Medicaid does not reimburse for skilled nursing visits when the administration of a tuberculosis skin test is the only purpose for the visit.

Medication Management Coverage Guidelines

Medication management visits must adhere to the following guidelines:

- *All nursing services must be consolidated into one visit whenever possible.* A medication management visit *may* be billable on the same DOS as a home health skilled nursing visit or personal care supervisory visit when more than one visit is *medically necessary*.
- An ongoing assessment visit is not covered if the member has received a medication management visit within the past 62 days.
- The 30-visit home health PA threshold includes medication management visits.
- If a member is unable to fill his or her own insulin syringes by the many methods available, prefilled insulin pens are not an appropriate alternative, and a pharmacy is unavailable to fill syringes, medication management visits to fill syringes may be authorized.
- Medication set up may be medically necessary to ensure the medication program is followed correctly, especially when a member is taking multiple prescriptions at various times during the day. It may also be necessary to allow safe delegation of administration to an unlicensed caregiver.
  - Alternatives to setting up medications, such as picture charts, color coding, and alarm caps, should be considered.
  - Medication set up is normally done on a biweekly basis. Requests for a more frequent set up schedule must be documented as medically necessary and will be determined on a case-by-case basis.
  - Any additional visit to set up missing medications is not covered because Wisconsin Medicaid only reimburses for a completed service, not a partial service. For example, if a medication was not reordered appropriately to completely fill out a member's two-week planner, an additional visit to finish filling out the planner would not be covered.
- In some cases, a mix of home health skilled nursing visits and medication management visits is appropriate. To determine if a visit is for the purpose of medication management or home health skilled nursing, the provider should ask "If no medication management services were needed, would the visit otherwise qualify as a covered home health skilled nursing visit?"
- Medication management visits may be medically necessary and appropriate on a PRN, or "as needed," basis. Such PRN visits may be included in PA requests that include documentation that the request is reasonable.

Medication Management Covered Services

A medication management visit may include the following services:

- Administering medication, other than intravenous, requiring the skills of a nurse when administration cannot be delegated safely to a home health aide or PCW.
  - Intravenous fluid or medication administration may be billed as a home health skilled nursing visit.
  - Intramuscular and subcutaneous injections are considered medication management visits. This includes sliding scale insulin injections.
- Prefilling syringes for self-injection when the member is not capable and a pharmacy is not available.
- Setting up medication for self-administration, administration, or assistance with administration by an unlicensed caregiver when the member is not capable and a pharmacy is not available. Medication set up includes changing medications, programming an electronic medication dispenser, and instructing the member about the medication program and use of the dispenser.
- Providing other services directly related to a medication program, such as teaching related to a member medication regimen, determined on a case-by-case basis.

Medication Management Overview

A medication management visit is a medically necessary visit in which a nurse provides medication management when the member is physically or cognitively unable to follow a medication program without assistance, and no other willing and able caregiver is available.

Only a nurse may provide medication management services for the member. The following tasks may be delegated by an RN to either a home health aide or PCW:

- Assistance with medication administration.
- Medication administration other than by intramuscular or subcutaneous injection, nasogastric, or intravenous administration.

Providers cannot submit claims using procedure code T1502 (Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit) for medication assistance or administration provided by a home health aide or PCW.

If skilled nursing services are provided in conjunction with medication management services, the visit is considered a home health skilled nursing visit.

Oral Medications

The administration of oral medications to a member is not a reasonable or medically necessary skilled nursing service except when the complexity of the member's condition, the nature of the drugs prescribed, and the number of drugs prescribed require the skills of a licensed nurse to detect and evaluate side effects or reactions. The medical record must document the specific circumstances that cause administration of an oral medication to require skilled observation and assessment.

Psychiatric Medication Management Visits

Medication management services for members with mental illness are generally provided under other BadgerCare Plus or Medicaid benefits.

Medication management services are provided as part of CSP services; therefore, they are not covered home health services for members receiving covered CSP services as stated in DHS 107.11(5)(h), Wis. Admin. Code. Refer to the CSP service area for further information. Medication management services are also not covered home health services when these services are provided under outpatient psychotherapy and day treatment services, according to DHS 107.11(5)(h), Wis. Admin. Code.

PA requests must document information on a member's enrollment status in a CSP, day treatment, or other mental health service that can provide medication management services to the member.

All home health skilled nursing criteria apply when medication management services for mental health members are provided under home health services. This includes the following:

- The services are medically necessary, and the member requires a considerable and taxing effort to leave the residence or cannot reasonably obtain these services outside the residence.
- The medication management service must meet the criteria of the home health benefit.

If providers are not certain what resources are available for a particular mental health member, contact the member's county community services board per ch. 51.42, Wis. Stats. This agency, as specified under ch. 51, Wis. Stats., is responsible for providing or arranging services for its citizens with mental health needs. Contact the member's local county or tribal agency for the agency's contact information.

Noncovered Services

Core Plan Noncovered Services

The following services are not covered under the BadgerCare Plus Core Plan:

- Case management.
- Chiropractic.
- Enteral nutrition products.
- Hearing, including hearing instruments, cochlear implants, and bone-anchored hearing devices, hearing aid batteries, and repairs.
- Home care (home health, personal care, private duty nursing).
- Hospice.
- Inpatient mental health and substance abuse treatment.
- Non-emergency transportation (i.e., common carrier, specialized medical vehicle).
- Nursing home.
- Podiatry.
- Prenatal care coordination.
- Routine vision.
- School-based services.

Definition of Noncovered Services

A noncovered service is a service, item, or supply for which reimbursement is not available. DHS 101.03(103) and 107, Wis. Admin. Code, contain more information about noncovered services. In addition, DHS 107.03, Wis. Admin. Code, contains a general list of noncovered services.

Member Payment for Noncovered Services

A provider may collect payment from a member for noncovered services if certain conditions are met.

Providers may not collect payment from a member, or authorized person acting on behalf of the member, for certain noncovered services or activities provided in connection with covered services, including the following:

- Charges for missed appointments.
- Charges for telephone calls.
- Charges for time involved in completing necessary forms, claims, or reports.
- Translation services.

Missed Appointments

The federal CMS does not allow state Medicaid programs to permit providers to collect payment from a member, or authorized person acting on behalf of the member, for a missed appointment.

Avoiding Missed Appointments

ForwardHealth offers the following suggestions to help avoid missed appointments:

- Remind members of upcoming appointments (by telephone or postcard) prior to scheduled appointments.
- Encourage the member to call his or her local county or tribal agency if transportation is needed.
- If the appointment is made through the HealthCheck screening or targeted case management programs, encourage the staff from those programs to ensure that the scheduled appointments are kept.

Translation Services

Translation services are considered part of the provider's overhead cost and are not separately reimbursable. Providers may not collect payment from a member, or authorized person acting on behalf of the member, for translation services.

Providers should call the Affirmative Action and Civil Rights Compliance Officer at (608) 266-9372 for information about when translation services are required by federal law. Providers may also write to the following address:

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

Private Duty Nursing Services

Daylight Savings Time

Wisconsin Medicaid reimburses only for the number of hours actually worked. Providers who work when daylight savings time ends are still required to adhere to the limitations on authorized services. Authorization is limited to 12 hours in each 24-hour period and 60 hours in a calendar week for any one nurse. Nurses are expected to adjust their schedules in advance to accommodate changes in the clock time.

Emergency Procedures

As required by DHS 105.16(10)(e), Wis. Admin. Code, all agencies providing PDN are required to have the following back-up and emergency procedures in place:

- Have identified another nurse on the case as a backup to provide services to the member in the event the scheduled nurse is temporarily unable to provide services. Providers are required to inform members of the backup nurse's name before the backup nurse provides services.
- Have a written plan for member-specific emergency procedures in the case of a life-threatening situation, fire, or severe weather warnings. Home health agencies are required to give this plan to the member and all caregivers prior to the initiation of these procedures.
- Take appropriate action in the case of any significant accident, injury, or adverse change in the member's condition. Nurses are required to immediately notify the member's physician, guardian (if any), and any other responsible person designated in writing by the member or member's legal representative.

Member Eligibility for Services

According to DHS 107.12(1)(a), Wis. Admin. Code, a member is eligible for PDN services if he or she:

- Requires a total of eight or more hours of direct skilled nursing services in a 24-hour period according to the POC.
- Does not reside in a hospital or nursing facility.
- Has a written POC specifying the medical necessity for PDN services.

Ventilator-Dependent Members

In accordance with DHS 107.113(1), Wis. Admin. Code, a ventilator-dependent member is eligible for respiratory care when he or she meets all of the criteria for PDN services and meets the following requirements:

- Is medically dependent on a ventilator for life support at least six hours per day. In addition, the member is required to meet one of the following two conditions:
  - Has been hospitalized for at least 30 consecutive days for his or her respiratory condition. The 30 consecutive days may occur in more than one hospital or nursing facility.
  - If the member has been hospitalized for less than 30 days, the member's enrollment for services will be determined by the DHCAA Chief Medical Officer on a case-by-case basis. The Chief Medical Officer's determination may include discussions with the member's pulmonologist and/or primary care physician to evaluate the member's diagnosis, prognosis, history of hospitalizations for the respiratory condition, and weaning attempts, when appropriate.
- Has adequate social support to be treated at home and desires to be treated at home.
- May have ventilator care safely provided at home.

Member Medical Record

Home health agencies are required to maintain a medical record for each member receiving PDN services as stated in DHS 105.16(10)(d), Wis. Admin. Code. The record must document the nature and scope of all services provided and be systematically organized and readily accessible to ForwardHealth. The medical record must include all of the following:

- Member identification information.
- The member's condition, problems, progress, and all services rendered.
- Appropriate hospital information supplied by the hospital, including discharge information, diagnosis, current patient status, and post-discharge POC.
- An admission evaluation and assessment of the member.
- All medical orders, including the current physician written POC and all interim physician's orders. The Plan of Care chapter contains further information about a physician's verbal orders.
- A consolidated list of medications, including start and stop dates, dosage, route of administration, and frequency. This list must be reviewed and updated for each nursing visit, if necessary.
- Progress notes posted as frequently as necessary to clearly and accurately document the member's status and services provided. A "progress note" is a written notation, timed, dated, and signed by a member of the health team providing covered services, that summarizes facts about the care furnished and the member's response during a given period of time.
- Clinical notes written, timed, signed, and dated the day service is provided and incorporated into the medical record within seven days. A copy of these notes should be maintained in the record in the member's home. These notes are a notation of contact with a member that document the PDN services provided and should do the following:
  - Describe the member's medical status, including signs and symptoms.
  - List the time and date of the contact, a description of treatment and drugs administered, and the member's reaction.
  - Describe any changes in the member's physical or emotional condition and any nursing intervention.

    Nurses are encouraged to write clinical notes as services are provided and complete them by the end of each shift. These notes should be utilized by nurses performing services during subsequent shifts in order to maintain continuity of care.

- Written summaries of the member's care provided by the nurse to the physician at least every 62 days.

The following information must be included in the documentation concurrent to the notation of service in both progress notes and clinical notes:

- The date and time of service.
- The signature and title of the rendering provider.

All physician-ordered treatments and interventions included in the POC must be documented in the member's medical record.

For ventilator-dependent members, the ventilator settings, parameters, and the ventilator checks must also be documented in the member's medical record at least for each nurses' shift.

Members with Changes to Nursing Needs

During a member's course of treatment, the number of hours of nursing services he or she requires may change. As a result, the member may transition from home health services to PDN services or the member may no longer require PDN services. When a change in the level of service occurs, providers are required to submit a new PA/RF to Wisconsin Medicaid. In this situation, an amendment to the current PA/RF will not be accepted.

Members Changing to Private Duty Nursing

If the condition of a recipient receiving home health skilled nursing services changes to the point that eight or more hours of direct, skilled nursing care are required in a calendar day, the member is no longer eligible for home health skilled nursing services. For reimbursement of covered services, the provider should request PA for PDN services.

Place of Service

As stated in DHS 107.12(1)(a), Wis. Admin. Code, members who are authorized to receive PDN services in the home may make use of approved hours of service outside the home setting during those hours when a member's normal life activities take him or her outside the home setting.

Providers of Services

Only RNs and LPNs can provide PDN. The following PDN services can only be performed by an RN:

- The initial evaluation visit.
- Initiating the physician's POC and any necessary revisions.
- Providing those services that require the care of an RN as defined in ch. N 6, Wis. Admin Code.
- Initiating appropriate preventive and rehabilitative procedures.
- Regularly evaluating the member's needs.

Nursing services not requiring an RN may be provided by an LPN under the supervision of an RN. An LPN's duties include the following:

- Performing nursing acts delegated by an RN under ch. N 6.03, Wis. Admin. Code.
- Assisting the member in learning appropriate self-care techniques.
- Meeting the nursing needs of the member according to the written POC. All nursing acts performed must be within the professional scope of practice for the LPN.

In accordance with DHS 105.16(10)(a)3, Wis. Admin. Code, both RNs and LPNs are required to do the following:

- Arrange for or provide health care counseling within the scope of nursing practice to the member and the member's family in meeting the needs related to the member's condition.
- Provide coordination of care for the member, including ensuring that provision is made for all required hours of care for the member.
- Accept only those delegated medical acts for which there are written or verbal orders and for which the nurse has appropriate training or experience.
- Within 24 hours of providing service, prepare written clinical notes that document the care provided and incorporate them into the member's medical record within seven days.
- Promptly inform the physician and other personnel participating in the member's care of changes in the member's condition and needs.

Ventilator-Dependent Members

Only RNs and LPNs may provide PDN services to ventilator-dependent members. The provider is required to document that the appropriate home health agency staff are qualified to perform all of the following services:

- *Tracheostomy care*. Stoma care, suctioning, humidification, changing a tracheostomy tube, and emergency procedures for tracheostomy care.
- *Oxygen therapy*. Operation of oxygen systems and auxiliary oxygen devices, and written documentation of the member's oxygen needs.
- *Operation and interpretation of monitoring devices*. Types of cardio-respiratory monitoring, pulse oximetry, and capnography.
- *Operation of ventilators*. Positive pressure or negative pressure ventilation.
- *Other respiratory therapies*. Continuous positive airway pressure, chest physiotherapy, respiratory assessment, and operation of aerosol and humidity devices.
- *Pulmonary rehabilitation*. Maintenance and restoration of the member's physical functioning, modification of the member's immediate living environment, assessment of the member's activities of daily living.

Qualifying Hours of Care

To determine if a member receives eight or more hours of direct skilled nursing services, add up the total hours of direct skilled nursing care provided by all caregivers, including home health agencies, independent nurses, and skilled cares provided by family or friends. If the total time required for these cares is equivalent to eight or more hours, the member is eligible for PDN. The POC is required to include the actual amount of time to be spent on medically necessary direct cares that require the skills of a licensed nurse.

For this purpose, Medicaid-covered skilled nursing services may include, but are not limited to, the following:

- Injections.
- Intravenous feedings.
- Gastrostomy feedings (include the time needed to begin, disconnect, and flush — not the entire time the feeding is dispensing).
- Nasopharyngeal and tracheostomy suctioning.
- Insertion and sterile irrigation of catheters.
- Application of dressings involving prescription medications and aseptic techniques.

- Treatment of extensive decubitus ulcers or other widespread skin disorders.

Reasonable time for record keeping, travel, staff training, supervision, and case management are allowable costs that have been included in the rates established for PDN hours. Therefore, the time spent on these activities is not separately reimbursable.

If the member requires fewer than eight hours of direct skilled nursing services in a 24-hour period, he or she may be eligible for home health skilled nursing services. A member cannot be concurrently enrolled for both PDN and intermittent part-time skilled visits provided by nurses.

Reimbursement Requirements

Wisconsin Medicaid reimburses PDN services as part of the PDN benefit if the services:

- Meet the criteria to be classified as PDN services.
- Are prior authorized.
- Are prescribed by a physician in accordance with s. 49.46(2), Wis. Stats.
- Are provided to members enrolled under s. 49.47(6)(a), Wis. Stats.
- Are implemented according to DHS 107, Wis. Admin. Code.
- Are provided in accordance with the member's POC. Services provided to the member that are not on the POC are not covered services.

Managed Care

5

Archive Date:07/01/2009

Managed Care:Claims

Appeals to BadgerCare Plus and Wisconsin Medicaid

The provider has 60 calendar days to file an appeal with BadgerCare Plus or Wisconsin Medicaid after the HMO or SSI HMO either does not respond in writing within 45 calendar days or if the provider is dissatisfied with the HMO's or SSI HMO's response.

BadgerCare Plus or Wisconsin Medicaid will not review appeals that were not first made to the HMO or SSI HMO. If a provider sends an appeal directly to BadgerCare Plus or Wisconsin Medicaid without first filing it with the HMO or SSI HMO, the appeal will be returned to the provider.

Appeals will only be reviewed for enrollees who were eligible for and who were enrolled in a BadgerCare Plus HMO or Medicaid SSI HMO on the date of service in question.

Appeals must be made in writing and must include:

- A letter, clearly marked "APPEAL," explaining why the claim should be paid or a completed Managed Care Program Provider Appeal form.
- A copy of the claim, clearly marked "APPEAL."
- A copy of the provider's letter to the HMO or SSI HMO.
- A copy of the HMO's or SSI HMO's response to the provider.
- Any documentation that supports the case.

The appeal will be reviewed and any additional information needed will be requested from the provider or the HMO or SSI HMO. Once all pertinent information is received, BadgerCare Plus or Wisconsin Medicaid has 45 calendar days to make a final decision.

The provider and the HMO or SSI HMO will be notified in writing of the final decision. If the decision is in favor of the provider, the HMO or SSI HMO is required to pay the provider within 45 calendar days of the final decision. The decision is final, and all parties must abide by the decision.

Appeals to HMOs and SSI HMOs

Providers are required to first file an appeal directly with the BadgerCare Plus HMO or Medicaid SSI HMO within 60 calendar days of receipt of the initial denial. Providers are required to include a letter explaining why the HMO or SSI HMO should pay the claim. The appeal should be sent to the address indicated on the HMO's or SSI HMO's denial notice.

The HMO or SSI HMO then has 45 calendar days to respond in writing to the appeal. The HMO or SSI HMO decides whether to pay the claim and sends the provider a letter stating the decision.

If the HMO or SSI HMO does not respond in writing within 45 calendar days, or if the provider is dissatisfied with the HMO's or SSI HMO's response, the provider may send a written appeal to ForwardHealth within 60 calendar days.

Claims Submission

BadgerCare Plus HMOs and Medicaid SSI HMOs have requirements for timely filing of claims, and providers are required to follow HMO and SSI HMO claims submission guidelines. Contact the enrollee's HMO or SSI HMO for organization-specific submission deadlines.

Extraordinary Claims

Extraordinary claims are BadgerCare Plus or Medicaid claims for a BadgerCare Plus HMO or Medicaid SSI HMO enrollee that have been denied by an HMO or SSI HMO but may be paid as fee-for-service claims.

The following are some examples of extraordinary claims situations:

- The enrollee was not enrolled in an HMO or SSI HMO at the time he or she was admitted to an inpatient hospital, but then enrolled in an HMO or SSI HMO during the hospital stay. In this case, all claims related to the stay (including physician claims) should be

submitted to fee-for-service. These claims (including physician claims) must include admittance and discharge dates.
- The claims are for orthodontia/prosthodontia services that began before HMO or SSI HMO coverage. Include a record with the claim of when the bands were placed.

Submitting Extraordinary Claims

When submitting an extraordinary claim, include the following:
- A legible copy of the completed claim form, in accordance with billing guidelines.
- A letter detailing the problem, any claim denials, and any steps taken to correct the situation.

Submit extraordinary claims to:

ForwardHealth
Managed Care Extraordinary Claims
PO Box 6470
Madison WI 53716-0470

Medicaid as Payer of Last Resort

Wisconsin Medicaid is the payer of last resort for most covered services, even when a member is enrolled in a BadgerCare Plus HMO or Medicaid SSI HMO. Before submitting claims to HMOs and SSI HMOs, providers are required to submit claims to other health insurance sources. Contact the enrollee's HMO or SSI HMO for more information about billing other health insurance sources.

Provider Appeals

When a BadgerCare Plus HMO or Medicaid SSI HMO denies a provider's claim, the HMO or SSI HMO is required to send the provider a notice informing him or her of the right to file an appeal.

An HMO or SSI HMO network or non-network provider may file an appeal to the HMO or SSI MCO when:
- A claim submitted to the HMO or SSI HMO is denied payment.
- The full amount of a submitted claim is not paid.

Providers are required to file an appeal with the HMO or SSI HMO *before* filing an appeal with ForwardHealth.

Covered and Noncovered Services

Covered Services

HMOs

Although BadgerCare Plus requires contracted HMOs to provide all medically necessary covered services, the following services may be provided by BadgerCare Plus HMOs at their discretion:

- Dental.
- Chiropractic.

If the HMO does not include these services in their benefit package, the enrollee receives the services on a fee-for-service basis.

SSI HMOs

Wisconsin Medicaid requires contracted Medicaid SSI HMOs to provide all medically necessary Medicaid-covered services. If the SSI HMO does not include services such as chiropractic or dental, the enrollee receives these services on a Medicaid fee-for-service basis.

Noncovered Services

The following are not covered by BadgerCare Plus HMOs or Medicaid SSI HMOs but are provided to enrollees on a fee-for-service basis:

- CSP benefits.
- Crisis intervention services.
- Environmental lead inspections.
- Milwaukee CCC services.
- Pharmacy services and some drug-related supplies.
- PNCC services.
- Provider-administered drugs, including all "J" codes, drug-related "Q" codes, procedure code S4993 (Contraceptive pills for birth control), and a limited number of related administration codes.
- SBS.
- Targeted case management services.
- Transportation by common carrier (unless the HMO has made arrangements to provide this service as a benefit). Milwaukee HMOs and SSI HMOs are mandated to provide transportation for their enrollees.
- Directly observed therapy and monitoring for TB-only.

Enrollment

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 the member's HMO or SSI HMO. For example, in certain circumstances, women in high-risk pregnancies or women who are in the third trimester of pregnancy when they are enrolled in an HMO or SSI HMO *may* qualify for an exemption.

The contracts between the DHS and the HMO or SSI HMO provide more detail on the exemption and disenrollment requirements.

Enrollee Grievances

Enrollees have the right to file grievances about services or benefits provided by a BadgerCare Plus HMO or Medicaid SSI HMO. Enrollees also have the right to file a grievance when the HMO or SSI HMO refuses to provide a service. All HMOs and SSI HMOs are required to have written policies and procedures in place to handle enrollee grievances. Enrollees should be encouraged to work with their HMO's or SSI HMO's customer service department to resolve problems first.

If enrollees are unable to resolve problems by talking to their HMO or SSI HMO, or if they would prefer to speak with someone outside their HMO or SSI HMO, they should contact the Enrollment Specialist or the Ombudsman Program.

The contracts between the DHS and the HMO or SSI HMO describes the responsibilities of the HMO or SSI HMO and the DHS regarding enrollee grievances.

Enrollment Eligibility

BadgerCare Plus HMOs

Members enrolled in the BadgerCare Plus Standard Plan and the BadgerCare Plus Benchmark Plan are eligible for enrollment in a BadgerCare Plus HMO. BadgerCare Plus Core Plan members are enrolled in BadgerCare Plus HMOs.

An individual who receives the FPW program, the TB-Only benefit, SeniorCare, or Wisconsin Well Woman Medicaid cannot be enrolled in a BadgerCare Plus HMO.

Information about a member's HMO enrollment status and commercial health insurance coverage may be verified by using Wisconsin's EVS or the ForwardHealth Portal.

SSI HMOs

Members of the following subprograms are eligible for enrollment in a Medicaid SSI HMO:

- Individuals ages 19 and older, who meet the SSI and SSI-related disability criteria.
- Dual eligibles for Medicare and Medicaid.

Individuals who are living in an institution, nursing home, or participating in a Home and Community-Based Waiver program are not eligible to enroll in an SSI MCO.

Enrollment Periods

HMOs

Members are sent enrollment packets that explain the BadgerCare Plus HMOs and the enrollment process and provide contact information.

Once enrolled, enrollees may change their HMO assignment within the first 90 days of enrollment in an HMO (whether they chose the HMO or were auto-assigned). If an enrollee no longer meets the criteria, he or she will be disenrolled from the HMO.

SSI HMOs

Members are sent enrollment packets that explain the Medicaid SSI HMO's enrollment process and provide contract information. Once enrolled, enrollees may disenroll after a 60-day trial period and up to 120 days after enrollment and return to Medicaid fee-for-service if they choose.

Enrollment Specialist

The Enrollment Specialist provides objective enrollment, education, outreach, and advocacy services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees. The Enrollment Specialist is a knowledgeable single point of contact for enrollees, solely dedicated to managed care issues. The Enrollment Specialist is not affiliated with any health care agency.

The Enrollment Specialist provides the following services to HMO and SSI HMO enrollees:

- Education regarding the correct use of HMO and SSI HMO benefits.
- Telephone and face-to-face support.
- Assistance with enrollment, disenrollment, and exemption procedures.

Member Enrollment

HMOs

BadgerCare Plus HMO enrollment is either mandatory or voluntary based on ZIP code-defined enrollment areas as follows:

- Mandatory enrollment — Enrollment is mandatory for eligible members who reside in ZIP code areas served by two or more BadgerCare Plus HMOs. Some members may meet criteria for exemption from BadgerCare Plus HMO enrollment.
- Voluntary enrollment — Enrollment is voluntary for members who reside in ZIP code areas served by only one BadgerCare Plus HMO.

Members living in areas where enrollment is mandatory are encouraged to choose their BadgerCare Plus HMO. Automatic assignment to a BadgerCare Plus HMO occurs if the member does not choose a BadgerCare Plus HMO. In general, all members of a member's immediate family eligible for enrollment must choose the same HMO.

Members in voluntary enrollment areas can choose whether or not to enroll in a BadgerCare Plus HMO. There is no automatic assignment for members who live within ZIP codes where enrollment is voluntary.

SSI HMOs

Medicaid SSI HMO enrollment is either mandatory or voluntary as follows:

- Mandatory enrollment — Most SSI and SSI-related members are required to enroll in an SSI HMO. A member may choose the SSI HMO in which he or she wishes to enroll.
- Voluntary enrollment — Some SSI and SSI-related members may choose to enroll in an SSI HMO on a voluntary basis.

Ombudsman Program

The Ombudsmen, or Ombuds, are resources for enrollees who have questions or concerns about their BadgerCare Plus HMO or Medicaid SSI HMO. Ombuds provide advocacy and assistance to help enrollees understand their rights and responsibilities in the grievance and appeal process.

BadgerCare Plus HMO/Medicaid SSI HMO Ombudsmen
PO Box 6470
Madison WI 53716-0470

Release of Billing or Medical Information

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

Managed Care Information

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 BadgerCare Plus (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, claims submission, adjudication procedures, etc., which may differ from BadgerCare Plus fee-for-service policies and procedures. BadgerCare Plus HMO network providers should contact their HMO for more information about its policies and procedures.

Managed Care

Managed Care refers to the BadgerCare Plus HMO program, the Medicaid SSI HMO program, and the several special managed care programs available.

The primary goals of the managed care programs are:

- To improve the quality of member care by providing continuity of care and improved access.
- To reduce the cost of health care through better care management.

Managed Care Contracts

The contract between the DHS and the BadgerCare Plus HMO or Medicaid SSI HMO takes precedence over other ForwardHealth provider publications. Information contained in ForwardHealth publications is used by the DHS to resolve disputes regarding covered benefits that cannot be handled internally by HMOs and SSI HMOs. If there is a conflict, the HMO or SSI HMO contract prevails. If the contract does not specifically address a situation, Wisconsin Administrative Code ultimately prevails. HMO and SSI HMO contracts can be found on the Managed Care Organization area of the ForwardHealth Portal.

SSI HMO Program

Medicaid SSI HMOs provide the same benefits as Medicaid fee-for-service (e.g. medical, dental, mental health/substance abuse, vision, and prescription drug coverage) at no cost to their enrollees through a care management model. Medicaid members and SSI-related Medicaid members in certain counties may be eligible to enroll in an SSI HMO.

SSI-related Medicaid members receive coverage from Wisconsin Medicaid because of a disability determined by the Disability Determination Bureau.

Member Enrollment

Members who meet the following criteria are eligible to enroll in an SSI HMO:

- Medicaid-eligible individuals living in a service area that has implemented an SSI managed care program.
- Individuals ages 19 and older.
- Individuals who are enrolled in Wisconsin Medicaid and SSI or receive SSI-related Medicaid.

Individuals who are living in an institution or nursing home or are participating in a home and community-based waiver program or FamilyCare are not eligible to enroll in an SSI HMO.

Ozaukee and Washington Counties

Most SSI and SSI-related Medicaid members who reside in Ozaukee and Washington counties are required to choose the HMO in which they wish to enroll. Dual eligibles (members receiving Medicare and Wisconsin Medicaid) are not required to enroll. After a 60-day trial period and up to 120 days after enrollment, enrollees may disenroll and return to Medicaid fee-for-service if they choose.

Southwestern Wisconsin Counties

SSI members and SSI-related Medicaid members who reside in Buffalo, Jackson, La Crosse, Monroe, Trempealeau, and Vernon counties may choose to receive coverage from the HMO or remain in Wisconsin Medicaid fee-for-service.

Continuity of Care

Special provisions are included in the contract for SSI HMOs for continuity of care for SSI members and SSI-related Medicaid members. These provisions include the following:

- Coverage of services provided by the member's current provider for the first 60 days of enrollment in the SSI program or until the first of the month following completion of an assessment and care plan, whichever comes later. The contracted provider should get a referral from the member's HMO after this.
- Honoring a PA that is currently approved by Wisconsin Medicaid. The PA must be honored for 60 days or until the month following the HMO's completion of the assessment and care plan, whichever comes later.
- Coverage of drugs that an SSI member is currently taking until a prescriber orders different drugs.

Special Managed Care Programs

Wisconsin Medicaid has several special managed care programs that provide services to individuals who are elderly and/or who have disabilities. These members may be eligible to enroll in voluntary regional managed care programs such as Family Care, the PACE, and the Family Care Partnership Program. Additional information about these special managed care programs may be obtained from the Managed Care Organization area of the ForwardHealth Portal.

Prior Authorization

Prior Authorization Procedures

BadgerCare Plus HMOs and Medicaid SSI HMOs may develop PA 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

Copayments

Providers cannot charge Medicaid SSI HMO enrollees copayments for covered services except in cases where the Medicaid SSI HMO does not cover services such as dental, chiropractic, and pharmacy. When services are provided through fee-for-service or to members enrolled in a BadgerCare Plus HMO, copayments will apply.

Emergencies

Non-network providers may provide services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees in an emergency without authorization or in urgent situations when authorized by the HMO or SSI HMO. The contract between the DHS and the HMO or SSI HMO defines an emergency situation and includes general payment requirements.

Unless the HMO or SSI HMO has a written agreement with the non-network provider, the HMO or SSI HMO is only liable to the extent fee-for-service would be liable for an emergency situation, as defined in 42 CFR s. 438.114. Billing procedures for emergencies may vary depending on the HMO or SSI HMO. For specific billing instructions, non-network providers should always contact the enrollee's HMO or SSI HMO.

Non-network Providers

Providers who do not have a contract with the enrollee's BadgerCare Plus HMO or Medicaid SSI HMO are referred to as non-network providers. (HMO and SSI HMO network providers agree to payment amounts and billing procedures in a contract with the HMO or SSI HMO.) Non-network providers are required to direct enrollees to HMO or SSI HMO network providers except in the following situations:

- When a non-network provider is treating an HMO or SSI HMO enrollee for an emergency medical condition as defined in the contract between the DHS and the HMO or SSI HMO.
- When the HMO or SSI HMO has authorized (in writing) an out-of-plan referral to a non-network provider.
- When the service is not provided under the HMO's or SSI HMO's contract with the DHS (such as dental, chiropractic, and pharmacy services).

Non-network providers may not serve BadgerCare Plus HMO or Medicaid SSI HMO enrollees as private-pay patients.

Out-of-Area Care

BadgerCare Plus HMOs and Medicaid SSI HMOs may cover medically necessary care provided to enrollees when they travel outside the HMO's or SSI HMO's service area. The HMO or SSI HMO is required to authorize the services before the services are provided, except in cases of emergency. If the HMO or SSI HMO does not authorize the services, the enrollee may be held responsible for the cost of those services.

Provider Participation

Providers interested in participating in a BadgerCare Plus HMO or Medicaid SSI HMO or changing HMO or SSI HMO network affiliations should contact the HMO or SSI HMO for more information. Conditions and terms of participation in an HMO or SSI HMO are pursuant to specific contract agreements between HMOs or SSI HMOs and providers. An HMO or SSI HMO has the right to choose whether or not to contract with any provider.

Referrals

Non-network providers may at times provide services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees on a referral basis. Non-network providers are always required to contact the enrollee's HMO or SSI HMO. Before services are provided, the non-network provider and the HMO or SSI HMO should discuss and agree upon billing procedures and fees for all referrals. Non-network providers and HMOs or SSI HMOs should document the details of any referral in writing before services are provided.

Billing procedures for out-of-plan referrals may vary depending on the HMO or SSI HMO. For specific billing instructions, non-network providers should always contact the enrollee's HMO or SSI HMO.

Services Not Provided by HMOs or SSI HMOs

If an enrollee's BadgerCare Plus HMO's or Medicaid SSI HMO's benefit package does not include a covered service, such as chiropractic or dental services, any Medicaid-certified provider may provide the service to the enrollee and submit claims to fee-for-service.

Member Information

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Archive Date:07/01/2009

Member Information:Birth to 3 Program

Administration and Regulations

In Wisconsin, B-3 services are administered at the local level by county departments of community programs, human service departments, public health agencies, or any other public agency designated or contracted by the county board of supervisors. The DHS monitors, provides technical assistance, and offers other services to county B-3 agencies.

The enabling federal legislation for the B-3 Program is 34 CFR Part 303. The enabling state legislation is s. 51.44, Wis. Stats., and the regulations are found in ch. DHS 90, Wis. Admin. Code.

Providers may contact the appropriate county B-3 agency for more information.

Enrollment Criteria

A child from birth up to (but not including) age 3 is eligible for B-3 services if the child meets one of the following criteria:

- The child has a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.
- The child has at least a 25 percent delay in one or more of the following areas of development:
  - Cognitive development.
  - Physical development, including vision and hearing.
  - Communication skills.
  - Social or emotional development.
  - Adaptive development, which includes self-help skills.
- The child has atypical development affecting his or her overall development, as determined by a qualified team using professionally acceptable procedures and informed clinical opinion.

BadgerCare Plus provides B-3 information because many children enrolled in the B-3 Program are also BadgerCare Plus members.

Individualized Family Service Plan

A B-3 member receives an IFSP developed by an interdisciplinary team that includes the child's family. The IFSP provides a description of the outcomes, strategies, supports, services appropriate to meet the needs of the child and family, and the natural environment settings where services will be provided. All B-3 services must be identified in the child's IFSP.

Requirements for Providers

Title 34 CFR Part 303 for B-3 services requires all health, social service, education, and tribal programs receiving federal funds, including Medicaid providers, to do the following:

- Identify children who may be eligible for B-3 services. These children must be referred to the appropriate county B-3 program within *two working days* of identification. This includes children with developmental delays, atypical development, disabilities, and children who are substantiated as abused or neglected. For example, if a provider's health exam or developmental screen indicates that a child may have a qualifying disability or developmental delay, the child must be referred to the county B-3 program for evaluation. (Providers are encouraged to explain the need for the B-3 referral to the child's parents or guardians.)
- Cooperate and participate with B-3 service coordination as indicated in the child's IFSP. B-3 services must be provided by providers who are employed by, or under agreement with, a B-3 agency to provide B-3 services.
- Deliver B-3 services in the child's natural environment, unless otherwise specified in the IFSP. The child's natural environment includes the child's home and other community settings where children without disabilities participate. (Hospitals contracting with a county to provide therapy services in the child's natural environment must receive separate certification as a therapy group to be reimbursed for these therapy services.)
- Assist parents or guardians of children receiving B-3 services to maximize their child's development and participate fully in implementation of their child's IFSP. For example, an occupational therapist is required to work closely with the child's parents and caretakers to show them how to perform daily tasks in ways that maximize the child's potential for development.

Services

The B-3 Program covers the following types of services when they are included in the child's IFSP:

- Evaluation and assessment.
- Special instruction.
- OT.
- PT.
- SLP.
- Audiology.
- Psychology.
- Social work.
- Assistive technology.
- Transportation.
- Service coordination.
- Certain medical services for diagnosis and evaluation purposes.
- Certain health services to enable the child to benefit from early intervention services.
- Family training, counseling, and home visits.

Enrollment Categories

BadgerCare Expansion for Certain Pregnant Women

As a result of 2005 Wisconsin Act 25, the 2005-07 biennial budget, BadgerCare has expanded coverage to the following individuals:

- Pregnant non-U.S. citizens who are not qualified aliens but meet other eligibility criteria for BadgerCare.
- Pregnant individuals detained by legal process who meet other eligibility criteria for BadgerCare.

The BadgerCare Expansion for Certain Pregnant Women is designed to provide better birth outcomes.

Women are eligible for all covered services from the first of the month in which their pregnancy is verified or the first of the month in which the application for BadgerCare Plus is filed, whichever is later. Members are enrolled through the last day of the month in which they deliver or the pregnancy ends. Postpartum care is reimbursable *only* if provided as part of global obstetric care. Even though enrollment is based on pregnancy, these women are eligible for *all* covered services. (They are not limited to pregnancy-related services.)

These women are not presumptively eligible. Providers should refer them to the appropriate county/tribal social or human services agency where they can apply for this coverage.

Fee-for-Service

Pregnant non-U.S. citizens who are not qualified aliens and pregnant individuals detained by legal process receive care only on a fee-for-service basis. Providers are required to follow all program requirements (e.g., claims submission procedures, PA requirements) when providing services to these women.

Emergency Services for Non-U.S. Citizens

When BadgerCare Plus enrollment ends for pregnant non-U.S. citizens who are not qualified aliens, they receive coverage for emergency services. These women receive emergency coverage for 60 days after the pregnancy ends; this coverage continues through the end of the month in which the 60th day falls (e.g., a woman who delivers on June 20, 2006, would be enrolled through the end of August 2006).

BadgerCare Plus

BadgerCare Plus is a state-sponsored health care program that expands coverage of Wisconsin residents and ensures that all children in Wisconsin have access to affordable health care.

The key initiatives of BadgerCare Plus are:

- To ensure that all Wisconsin children have access to affordable health care.
- To ensure that 98 percent of Wisconsin residents have access to affordable health care.
- To streamline program administration and enrollment rules.
- To expand coverage and provide enhanced benefits for pregnant women.
- To promote prevention and healthy behaviors.

BadgerCare Plus expands enrollment in state-sponsored health care to the following:

- All uninsured children.
- More pregnant women.
- More parents and caretaker relatives.
- Parents with children in foster care who are working to reunify their families.
- Young adults exiting out-of-home care, such as foster care, because they have turned 18 years of age.
- Certain farmers and other self-employed parents and caretaker relatives.

Where available, all BadgerCare Plus members will be 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.

Benefit Plans under BadgerCare Plus

BadgerCare Plus is comprised of two benefit plans, the BadgerCare Plus Standard Plan and the BadgerCare Plus Benchmark Plan. The services covered under the Standard Plan are the same as the Wisconsin Medicaid program. The Benchmark Plan is a more limited plan, modeled after commercial insurance.

BadgerCare Plus Standard Plan

The Standard Plan covers children, parents and caretaker relatives, young adults aging out of foster care, and pregnant women with incomes at or below 200 percent of the FPL.

BadgerCare Plus Benchmark Plan

The Benchmark Plan was adapted from Wisconsin's largest commercial, low-cost health care plan. The Benchmark Plan is for children and pregnant women with incomes above 200 percent of the FPL and certain self-employed parents, such as farmers with incomes above 200 percent of the FPL.

Express Enrollment for Children and Pregnant Women

EE for Pregnant Women Benefit is a limited benefit category that allows a pregnant woman to receive immediate pregnancy-related outpatient services while her application for full-benefit BadgerCare Plus is processed. Enrollment is not restricted based on the member's other health insurance coverage. Therefore, a pregnant woman who has other health insurance may be enrolled in the benefit.

To determine enrollment for EE for Pregnant Women, providers should use the income limits for 200 percent and 300 percent of the FPL.

The EE for Children Benefit allows certain members under 18 years of age to receive BadgerCare Plus benefits under the BadgerCare Plus Standard Plan while an application for BadgerCare Plus is processed.

Fee-for-Service

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

Family Planning Waiver

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

The goal of the FPW is to provide women with information and services to assist them in preventing pregnancy, making BadgerCare Plus enrollment due to pregnancy less likely. Providers should explain the purpose of the FPW to women and encourage them to contact their local county or tribal agency to determine their enrollment options if they are not interested in receiving, or do not wish to receive, contraceptive services.

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

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

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

and hysterectomies). If a medical condition, other than an STD, is discovered during contraceptive-related services, treatment for the medical condition is not covered under the FPW.

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

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

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

Temporary Enrollment for the Family Planning Waiver

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

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

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

ForwardHealth and ForwardHealth interChange

ForwardHealth brings together many DHS health care programs with the goal to create efficiencies for providers and to improve health outcomes for members. ForwardHealth interChange is the DHS claims processing system that supports multiple state health care programs and Web services, including:

- BadgerCare Plus.
- BadgerCare Plus and Medicaid Managed care programs.
- SeniorCare.
- WCDP.
- WIR.
- Wisconsin Medicaid.
- Wisconsin Well Woman Medicaid.
- WWWP.

ForwardHealth interChange is supported by the state's fiscal agent, EDS.

Limited Benefit Categories Overview

Certain members may be enrolled in a limited benefit category. These limited benefit categories include the following:

- BadgerCare Plus Expansion for Certain Pregnant Women.
- EE for Children.
- EE for Pregnant Women.
- FPW, including the PE for the FPW.
- QDWI.
- QI-1.
- QMB Only.
- SLMB.
- TB-Only Benefit.

Members may be enrolled in full-benefit Medicaid or BadgerCare Plus and also be enrolled in certain limited benefit programs, including QDWI, QI-1, QMB Only, and SLMB. In those cases, a member has full Medicaid or BadgerCare Plus coverage in addition to limited

coverage for Medicare expenses.

Members enrolled in BadgerCare Plus Expansion for Certain Pregnant Women, FPW, EE for Children, EE for Pregnant Women, or the TB-Only Benefit cannot be enrolled in full-benefit Medicaid or BadgerCare Plus. These members receive benefits through the limited benefit category.

Providers should note that a member may be enrolled in more than one limited benefit category. For example, a member may be enrolled in the FPW and the TB-Only Benefit.

Providers are strongly encouraged to verify dates of enrollment and other coverage information using the EVS to determine whether a member is in a limited benefit category, receives full-benefit Medicaid or BadgerCare Plus, or both.

Providers are responsible for knowing which services are covered under a limited benefit category. If a member of a limited benefit category requests a service that is not covered under the limited benefit category, the provider may collect payment from the member if certain conditions are met.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for selected groups of people who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP, MA, Title XIX, or T19.

A Medicaid member is any individual entitled to benefits under Title XIX of the Social Security Act and under the Medical Assistance State Plan as defined in ch. 49, Wis. Stats.

Wisconsin Medicaid enrollment is determined on the basis of financial need and other factors. A citizen of the United States or a "qualified immigrant" who meets low-income financial requirements may be enrolled in Wisconsin Medicaid if he or she is in one of the following categories:

- Age 65 and older.
- Blind.
- Disabled.

Some needy and low-income people become eligible for Wisconsin Medicaid by qualifying for programs such as:

- Katie Beckett.
- Medicaid Purchase Plan.
- Subsidized adoption and foster care programs.
- SSI.
- WWWP.

Providers may advise these individuals or their representatives to contact their certifying agency for more information. The following agencies certify people for Wisconsin Medicaid enrollment:

- Local county or tribal agencies.
- Medicaid outstation sites.
- SSA offices.

In limited circumstances, some state agencies also certify individuals for Wisconsin Medicaid.

Medicaid fee-for-service members receive services through the traditional health care payment system under which providers receive a payment for each unit of service provided. Some Medicaid members receive services through state-contracted MCOs.

Qualified Disabled Working Individual Members

QDWI members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part A.

QDWI members are certified by their local county or tribal agency. To qualify, QDWI members are required to meet the following qualifications:

- Have income under 200 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.
- Have income or assets too high to qualify for QMB Only and SLMB.

Qualified Medicare Beneficiary-Only Members

QMB-Only members are a limited benefit category of Medicaid members. They receive payment of the following:

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

QMB-Only members are certified by their local county or tribal agency. QMB-Only members are required to meet the following qualifications:

- Have an income under 100 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Qualifying Individual 1 Members

QI-1 members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part B.

QI-1 members are certified by their local county or tribal agency. To qualify, QI-1 members are required to meet the following qualifications:

- Have income between 120 and 135 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Specified Low-Income Medicare Beneficiaries

SLMB members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part B.

SLMB members are certified by their local county or tribal agency. To qualify, SLMB members are required to meet the following qualifications:

- Have an income under 120 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Tuberculosis-Related Services-Only Benefit

The TB-Only Benefit is a limited benefit category that allows individuals with TB infection or disease to receive covered TB-related outpatient services.

Wisconsin Well Woman Medicaid

Wisconsin Well Woman Medicaid provides full Medicaid benefits to underinsured or uninsured women ages 35 to 64 who have been screened and diagnosed by WWWP or the FPW, meet all other enrollment requirements, and are in need of treatment for any of the following:

- Breast cancer.

- Cervical cancer.
- Precancerous conditions of the cervix.

Services provided to women who are enrolled in Well Woman Medicaid are reimbursed through Medicaid fee-for-service.

Enrollment Responsibilities

General Information

Members have certain responsibilities per DHS 104.02, Wis. Admin. Code, and the Medicaid Enrollment and Benefits booklet or the BadgerCare Plus Enrollment and Benefits booklet.

Loss of Enrollment — Financial Liability

Some covered services consist of a series of sequential treatment steps, meaning more than one office visit is required to complete treatment.

In most cases, if a member loses enrollment midway through treatment, BadgerCare Plus will *not* reimburse services (including prior authorized services) after enrollment has lapsed.

Members are financially responsible for any services received after their enrollment has been terminated. If the member wishes to continue treatment, it is a decision between the provider and the member whether the service should be given and how the services will be paid. The provider may collect payment from the member if the member accepts responsibility for payment of a service and certain conditions are met.

To avoid misunderstandings, it is recommended that providers remind members that they are financially responsible for any continued care after enrollment ends.

To avoid potential reimbursement problems that can arise when a member loses enrollment midway through treatment, the provider is encouraged to verify the member's enrollment using the EVS or the ForwardHealth Portal prior to providing each service, even if an approved PA request is obtained for the service.

Member Cooperation

Members are responsible for giving providers full and accurate information necessary for the correct submission of claims. If a member has other health insurance, it is the member's obligation to give full and accurate information to providers regarding the insurance.

Members Should Present Card

It is important that providers determine a member's enrollment and other insurance coverage *prior to* each DOS that services are provided. Pursuant to DHS 104.02(2), Wis. Admin. Code, a member should inform providers that he or she is enrolled in BadgerCare Plus or Wisconsin Medicaid and should present a current ForwardHealth identification card before receiving services.

Note: Due to the nature of their specialty, certain providers — such as anesthesiologists, radiologists, DME suppliers, independent laboratories, and ambulances — are not always able to see a member's ForwardHealth identification card because they might not have direct contact with the member prior to providing the service. In these circumstances, it is still the provider's responsibility to obtain member enrollment information.

Prior Identification of Enrollment

Except in emergencies that preclude prior identification, members are required to inform providers that they are receiving benefits and must present their ForwardHealth identification card before receiving care. If a member forgets his or her ForwardHealth card, providers may verify enrollment without it.

Reporting Changes to Caseworkers

Members are required to report certain changes to their caseworker at their certifying agency. These changes include, but are not limited to,

the following:

- A new address or a move out of state.
- A change in income.
- A change in family size, including pregnancy.
- A change in other health insurance coverage.
- Employment status.
- A change in assets for members who are over 65 years of age, blind, or disabled.

Enrollment Rights

Appealing Enrollment Determinations

Applicants and members have the right to appeal certain decisions relating to BadgerCare Plus or Medicaid enrollment. An applicant, a member, or authorized person acting on behalf of the applicant or member, or former member may file the appeal with the DHA.

Pursuant to HA 3.03, Wis. Admin. Code, an applicant, member, or former member may appeal any adverse action or decision by an agency or department that affects their benefits. Examples of decisions that may be appealed include, but are not limited to, the following:

- Individual was denied the right to apply.
- Application for BadgerCare Plus or Wisconsin Medicaid was denied.
- Application for BadgerCare Plus or Wisconsin Medicaid was not acted upon promptly.
- Enrollment was unfairly discontinued, terminated, suspended, or reduced.

In the case when enrollment is cancelled or terminated, the date the member, or authorized person acting on behalf of the member, files an appeal with the DHA determines what continuing coverage, if any, the member will receive until the hearing decision is made. The following scenarios describe the coverage allowed for a member who files an appeal:

- If a member files an appeal before his or her enrollment ends, coverage will continue pending the hearing decision.
- If a member files an appeal within 45 days after his or her enrollment ends, a hearing is allowed but coverage is not reinstated.

If the member files an appeal more than 45 days after his or her enrollment ends, a hearing is not allowed. Members may file an appeal by submitting a Request for Fair Hearing form.

Claims for Appeal Reversals

If a claim is denied due to termination of enrollment, a hearing decision that reverses that determination will allow the claim to be resubmitted and paid. The provider is required to obtain a copy of the appeal decision from the member, attach the copy to the previously denied claim, and submit both to ForwardHealth at the following address:

ForwardHealth
Specialized Research
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

If a provider has not yet submitted a claim, the provider is required to submit a copy of the hearing decision along with a paper claim to Specialized Research.

As a reminder, claims submission deadlines still apply even to those claims with hearing decisions.

Freedom of Choice

Members may receive covered services from *any* willing Medicaid-certified provider, unless they are enrolled in a state-contracted MCO or assigned to the Member Lock-In Program.

General Information

Members are entitled to certain rights per DHS 103, Wis. Admin. Code.

Notification of Discontinued Benefits

When the DHS intends to discontinue, suspend, or reduce a member's benefits, or reduce or eliminate coverage of services for a general class of members, the DHS sends a written notice to members. This notice is required to be provided at least 10 days before the effective date of the action.

Prompt Decisions on Enrollment

Individuals applying for BadgerCare Plus or Wisconsin Medicaid have the right to prompt decisions on their applications. Enrollment decisions are made within 60 days of the date the application was signed for those with disabilities and within 30 days for all other applicants.

Requesting Retroactive Enrollment

An applicant has the right to request retroactive enrollment when applying for BadgerCare Plus or Wisconsin Medicaid. Enrollment may be backdated to the first of the month three months prior to the date of application for eligible members. Retroactive enrollment does not apply to QMB-Only members.

Identification Cards

ForwardHealth Identification Cards

Each enrolled member receives an identification card. Possession of a program identification card does not guarantee enrollment. It is possible that a member will present a card during a lapse in enrollment; therefore, it is essential that providers verify enrollment before providing services. Members are told to keep their cards even though they may have lapses in enrollment.

ForwardHealth Identification Card Features

The ForwardHealth identification card includes the member's name, 10-digit member ID, magnetic stripe, signature panel, and the Member Services telephone number. The card also has a unique, 16-digit card number on the front for internal program use.

The ForwardHealth card does not need to be signed to be valid; however, adult members are encouraged to sign their cards. Providers may use the signature as another means of identification.

The toll-free number on the back of each of the cards is for member use only. The address on the back of each card is used to return a lost card to ForwardHealth if it is found.

If a provider finds discrepancies with the identification number or name between what is indicated on the ForwardHealth card and the provider's file, the provider should verify enrollment with Wisconsin's EVS.

Identification Number Changes

Some providers may question whether services should be provided if a member's 10-digit identification number on his or her ForwardHealth card does not match the EVS response. If the EVS indicates the member is enrolled, services should be provided.

A member's identification number may change, and the EVS will reflect that change. However, ForwardHealth does not automatically send a replacement ForwardHealth card with the new identification number to the member. ForwardHealth cross-references the old and new identification numbers so a provider may submit claims with either number. The member may request a replacement ForwardHealth card that indicates the new number.

Member Name Changes

If a member's name on the ForwardHealth card is different than the response given from Wisconsin's EVS, providers should use the name from the EVS response. When a name change is reported and on file, a new card will automatically be sent to the member.

Deactivated Cards

When any member identification card has been replaced for any reason, the previous identification card is deactivated. If a member presents a deactivated card, providers should encourage the member to discard the deactivated card and use only the new card.

Although a member identification card may be deactivated, the member ID is valid and the member still may be enrolled in a ForwardHealth program.

If a provider swipes a ForwardHealth card using a magnetic stripe card reader and finds that it has been deactivated, the provider may request a second form of identification if he or she does not know the member. After the member's identity has been verified, providers may verify a member's enrollment by using one of the EVS methods such as AVR.

Defective Cards

If a provider uses a card reader for a ForwardHealth card and the magnetic stripe is defective, the provider should encourage the member to call Member Services at the number listed on the back of the member's card to request a new card.

If a member presents a ForwardHealth card with a defective magnetic stripe, providers may verify the member's enrollment by using an alternate enrollment verification method. Providers may also verify a member's enrollment by entering the member ID or 16-digit card number on a touch pad, if available, or by calling WiCall or Provider Services.

Lost Cards

If a member needs a replacement ForwardHealth card, he or she may call Member Services to request a new one.

If a member lost his or her ForwardHealth card or never received one, the member may call Member Services to request a new one.

Managed Care Organization Enrollment Changes

Members do not receive a new ForwardHealth card if they are enrolled in a state-contracted MCO or change from one MCO to another. Providers should verify enrollment with the EVS every time they see a member to ensure they have the most current managed care enrollment information.

Temporary Enrollment for BadgerCare Plus Family Planning Waiver Plan Temporary Cards

Qualified providers may issue white paper TE for BadgerCare Plus FPW Plan identification cards for women to use temporarily until they receive a ForwardHealth identification card. The identification card is included with the TE for BadgerCare Plus FPW Plan Application.

The TE for the FPW identification cards have the following message printed on them: "BadgerCare Plus Temporary Identification Card for Temporary Enrollment for the Family Planning Waiver Plan." Providers should accept the white TE for the FPW identification cards as proof of enrollment for the dates provided on the cards and are encouraged to keep a photocopy of the card.

Temporary Express Enrollment Cards

There are two types of temporary EE identification cards. One is issued for pregnant women and the other for children that are enrolled in BadgerCare Plus through EE. The EE cards are vaild for 14 days. Samples of temporary EE cards for children and pregnant women are available.

Providers may assist pregnant women with filling out an application for temporary ambulatory prenatal care benefits (formerly known as PE) through the online EE process. Express Enrollment identification cards are included on the bottom portion of the enrollment notice that is printed out and provided to the member after the on-line enrollment process is completed.

The paper application may also be used to apply for temporary ambulatory prenatal benefits for pregnant women. The beige paper identification card is attached to the last page of the application and provided to the woman after she completes the enrollment process. A sample of an EE temporary card from the back of the EE application is available.

The online EE process is also available for adults to apply for full BadgerCare Plus benefits for children. EE identification cards are included on the bottom portion of the enrollment notice that is printed out and provided to the member after the online enrollment process is completed. This temporary identification card is different, since providers may see more than one child listed if multiple children in one household are enrolled through EE. However; each child will receive his or her own ForwardHealth card after the application is submitted.

Each member who is enrolled through EE will receive a ForwardHealth card usually within three business days after the EE application is submitted and approved. To ensure children and pregnant women receive needed services in a timely manner, providers should accept the printed paper EE cards for children and either the printed paper EE card or the beige identification cards for pregnant women as proof of enrollment for the dates provided on the cards. Providers may use Wisconsin's EVS to verify enrollment for dates of service after those printed on the card. Providers are encouraged to keep a photocopy of the card.

Information is available for dates of service before April 1, 2009.

Temporary ForwardHealth Identification Cards

All Medicaid certifying agencies have the authority to issue green paper temporary identification cards to applicants who meet enrollment requirements. Temporary cards are usually issued only when an applicant is in need of medical services prior to receiving the ForwardHealth card. Providers should accept temporary cards as proof of enrollment. Eligible applicants may receive covered services for the dates shown on the card.

Providers are encouraged to keep a photocopy of the temporary card and should delay submitting claims for one week from the enrollment start date until the enrollment information is transmitted to ForwardHealth.

ForwardHealth accepts properly completed and submitted claims for covered services provided to applicants possessing a temporary card as long as the DOS is within the dates shown on the card.

If a claim is denied with an enrollment-related explanation, even though the provider verified the member's enrollment before providing the service, a good faith claim may be submitted.

Types of Identification Cards

ForwardHealth members receive an identification card upon initial eligibility determination. Identification cards may be in any of the following formats:

- White plastic ForwardHealth cards.
- Green paper temporary cards.
- Paper printout identification cards for EE for children and pregnant women and beige PE cards for pregnant women who are enrolled in BadgerCare Plus through EE.
- White paper PE for the FPW program cards.

Misuse and Abuse of Benefits

Examples of Member Abuse or Misuse

Examples of member abuse or misuse are included in DHS 104.02(5), Wis. Admin. Code.

Member Lock-In Program

If ForwardHealth determines that a member is abusing BadgerCare Plus or Medicaid services, the member may be required to designate a health care provider under the Member Lock-In Program. (A member has the right to appeal this action.) Members are required to designate, in any or all categories of health care, a Medicaid-certified provider of their choice. If a member fails to choose a provider, ForwardHealth may designate one based on claims data.

ForwardHealth notifies the member's chosen health care provider by letter. Another letter is also sent to the member. The provider has the option to decline to act as the selected health care provider for the member.

A member in the Lock-In Program who has already designated a provider can only receive the locked-in services from his or her designated provider. A provider who is *not* the designated provider of a Lock-In Program member for the locked-in services should not perform services for that member unless a referral is in place from the Lock-In provider.

Claims for restricted, nonemergency services performed by a provider who is not the designated provider are reviewed by ForwardHealth and may be denied.

Providers may obtain Lock-In information by using any of the enrollment verification methods. To obtain the name of the designated Lock-In provider, call Provider Services.

Providers May Make Referrals

The designated Lock-In provider may make referrals to other providers of medical services. ForwardHealth supplies Lock-In Program providers with referral forms that should be used when it is necessary to refer the member to another provider.

Reimbursement is made if the referral can be documented as medically necessary and the services are covered.

Providers may receive reimbursement for emergency services given without a referral to a locked-in member if the claim is accompanied by a full explanation of the emergency circumstances.

The designated provider is required to maintain all appropriate documentation in the member's medical records.

Notifying ForwardHealth

Providers are required to notify ForwardHealth if they have reason to believe that a person is misusing or abusing BadgerCare Plus or Medicaid benefits or the ForwardHealth identification card. Section 49.49, Wis. Stats., defines actions that represent member misuse or abuse of benefits and the resulting sanctions that may be imposed. Providers are under no obligation to inform the member that they are doing so. A provider may not confiscate a ForwardHealth card from a member in question.

If a provider suspects that a member is abusing his or her benefits or misusing his or her ForwardHealth card, providers are required to notify ForwardHealth by calling Provider Services or by writing to the following office:

Division of Health Care Access and Accountability
Bureau of Program Integrity
PO Box 309
Madison WI 53701-0309

ForwardHealth monitors member records and can impose sanctions on those who misuse or abuse their benefits. For more information on member misuse and abuse and the resulting sanctions, refer to s. 49.49, Wis. Stats.

Providers May Refuse to Provide Services

Providers may refuse to provide services to a BadgerCare Plus or Medicaid member in situations when there is reason to believe that the person presenting the ForwardHealth identification card is misusing or abusing it.

Members who abuse or misuse BadgerCare Plus or Wisconsin Medicaid benefits or their ForwardHealth card may have their benefits terminated or be subject to limitations under the Member Lock-In Program or to criminal prosecution.

Requesting Additional Proof of Identity

Providers may request additional proof of identity from a member if they suspect fraudulent use of a ForwardHealth identification card. If another form of identification is not available, providers can compare a person's signature with the signature on the back of the ForwardHealth identification card if it is signed. (adult members are encouraged to sign the back of their cards; however, it is not mandatory for members to do so.)

Verifying member identity, as well as enrollment, can help providers detect instances of fraudulent ForwardHealth card use.

Special Enrollment Circumstances

Medicaid Members from Other States

Wisconsin Medicaid does not pay for services provided to members enrolled in other state Medicaid programs. Providers are advised to contact other state Medicaid programs to determine whether the service sought is a covered service under that state's Medicaid program.

Members Traveling Out of State

When a member travels out of state but is within the United States (including its territories), Canada, or Mexico, BadgerCare Plus covers medical services in any of the following circumstances:

- An emergency illness or accident.
- When the member's health would be endangered if treatment were postponed.
- When the member's health would be endangered if travel to Wisconsin were undertaken.
- When PA has been granted to the out-of-state provider for provision of a nonemergency service.
- When there are coinsurance, copayment, or deductible amounts remaining after Medicare payment or approval for dual eligibles.

Note: Some providers located in a state that borders Wisconsin may be Wisconsin Medicaid certified as a border-status provider if the provider notifies ForwardHealth in writing that it is common practice for members in a particular area of Wisconsin to seek his or her medical services. Border-status providers follow the same policies as Wisconsin providers.

Non-U.S. Citizens — Emergency Services

Certain non-U.S. citizens who are not qualified aliens are eligible for BadgerCare Plus services only in cases of acute emergency medical conditions. Providers should use the appropriate ICD-9-CM diagnosis code to document the nature of the emergency.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of such severity that one could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the person's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Due to federal regulations, BadgerCare Plus does not cover services for non-U.S. citizens who are not qualified aliens related to routine prenatal or postpartum care, major organ transplants (e.g., heart, liver), or ongoing treatment for chronic conditions where there is no evidence of an acute emergent state. For the purposes of this policy, all labor and delivery is considered an emergency service.

Note: Babies born to certain non-qualifiying immigrants are eligible for Medicaid enrollment under the CEN option. However, babies born to women with incomes over 300 percent of the FPL are not eligible for CEN status. The baby may still qualify for BadgerCare Plus. These mothers should report the birth to the local agencies within ten calendar days.

A provider who gives emergency care to a non-U.S. citizen should refer him or her to the local county or tribal agency or ForwardHealth outstation site for a determination of BadgerCare Plus enrollment. Providers may complete the Certification of Emergency for Non-U.S. Citizens form, for clients to take to the local county or tribal agency in their county of residence where the BadgerCare Plus enrollment decision is made.

Providers should be aware that a client's enrollment does not guarantee that the services provided will be reimbursed by BadgerCare Plus.

Information for DOS before January 1, 2009, is available.

Out-of-State Youth Program

The OSY program is responsible for health care services provided to Wisconsin children placed outside the state in foster and subsidized adoption situations. These children are eligible for coverage. The objective is to assure that these children receive quality medical care.

Out-of-state providers not located in border-status-eligible communities may qualify as border-status providers if they deliver services as part of the OSY program. However, providers who have border status as part of the OSY program are reimbursed only for services provided to the specific foster care or subsidized adopted child. In order to receive reimbursement for services provided to other members, the provider is required to follow rules for out-of-state noncertified providers.

For subsidized adoptions, benefits are usually determined through the adoption assistance agreement and are provided by the state where the child lives. However, some states will not provide coverage to children with state-only funded adoption assistance. In these cases, Wisconsin will continue to provide coverage.

OSY providers are subject to the same regulations and policies as other certified border-status providers. For more information about the OSY program, call Provider Services or write to ForwardHealth at the following address:

ForwardHealth
Out-of-State Youth
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

Persons Detained by Legal Process

Most individuals detained by legal process are *not* eligible for BadgerCare Plus or Wisconsin Medicaid benefits. Only those individuals who qualify for the BadgerCare Plus Expansion for Certain Pregnant Women may receive benefits.

"Detained by legal process" means a person who is incarcerated (including some Huber Law prisoners) because of law violation or alleged law violation, which includes misdemeanors, felonies, delinquent acts, and day-release prisoners. The justice system oversees health care-related needs for individuals detained by legal process who do not qualify for the BadgerCare Plus Expansion for Certain Pregnant Women.

Retroactive Enrollment

Retroactive enrollment occurs when an individual has applied for BadgerCare Plus or Medicaid and enrollment is granted with an effective date prior to the date the enrollment determination was made. A member's enrollment may be backdated to allow retroactive coverage for medical bills incurred prior to the date of application.

The retroactive enrollment period may be backdated up to three months prior to the month of application if all enrollment requirements were met during the period. Enrollment may be backdated more than three months if there were delays in determining enrollment or if court orders, fair hearings, or appeals were involved.

Reimbursing Members in Cases of Retroactive Enrollment

When a member receives retroactive enrollment, he or she has the right to request the return of payments made to a Medicaid-certified provider for a covered service during the period of retroactive enrollment, according to DHS 104.01(11), Wis. Admin. Code. A Medicaid-certified provider is required to submit claims to Medicaid for covered services provided to a member during periods of retroactive enrollment. Medicaid cannot directly refund the member.

If a service(s) that requires PA was performed during the member's period of retroactive enrollment, the provider is required to submit a PA request and receive approval from Medicaid *before* submitting a claim.

If a provider receives reimbursement from Medicaid for services provided to a retroactively enrolled member and the member has paid for the service, the provider is required to reimburse the member or authorized person acting on behalf of the member (e.g., local General Relief agency) the full amount that the member paid for the service.

If a claim cannot be filed within 365 days of the DOS due to a delay in the determination of a member's retroactive enrollment, the provider is required to submit the claim to Timely Filing within 180 days of the date the retroactive enrollment is entered into Wisconsin's EVS (if the services provided during the period of retroactive enrollment were covered).

Spenddown to Meet Financial Enrollment Requirements

Occasionally, an individual with significant medical bills meets all enrollment requirements except those pertaining to income. These individuals are required to "spenddown" their income to meet financial enrollment requirements.

The certifying agency calculates the individual's spenddown (or deductible) amount, tracks all medical costs the individual incurs, and determines when the medical costs have satisfied the spenddown amount. (A payment for a medical service does not have to be made by the individual to be counted toward satisfying the spenddown amount.)

When the individual meets the spenddown amount, the certifying agency notifies ForwardHealth and the provider of the last service that the individual is eligible beginning on the date that the spenddown amount was satisfied.

If the individual's last medical bill is greater than the amount needed to satisfy the spenddown amount, the certifying agency notifies the affected provider by indicating the following:

- The individual is eligible for benefits as of the DOS on the last bill.
- A claim for the service(s) on the last bill should be submitted to ForwardHealth. (The claim should indicate the full cost of the service.)
- The portion of the last bill that the individual must pay to the provider.

The certifying agency also informs ForwardHealth of the individual's enrollment and identifies the following:

- The DOS of the final charges counted toward satisfying the spenddown amount.
- The provider number of the provider of the last service.
- The spenddown amount remaining to be satisfied.

When the provider submits the claim, the spenddown amount will automatically be deducted from the provider's reimbursement for the claim. The spenddown amount is indicated in the Member's Share element on the Medicaid Remaining Deductible Update form sent to providers by the member's certifying agency. The provider's reimbursement is then reduced by the amount of the member's obligation.

Prior Authorization

7

Archive Date:07/01/2009

Prior Authorization:Decisions

Approved Requests

PA requests are approved for varying periods of time based on the clinical justification submitted. The provider receives a copy of a PA decision notice when a PA request for a service is approved. Providers may then begin providing the approved service on the grant date given.

An approved request means that the requested *service*, not necessarily the code, was approved. For example, a similar procedure code may be substituted for the originally requested procedure code. Providers are encouraged to review approved PA requests to confirm the services authorized and confirm the assigned grant and expiration dates.

Listing Procedure Codes Approved as a Group on the Decision Notice Letter

In certain circumstances, ForwardHealth will approve a PA request for a group of procedure codes with a total quantity approved for the entire group. When this occurs, the quantity approved for the entire group of codes will be indicated with the first procedure code. All of the other approved procedure codes within the group will indicate a quantity of zero.

Providers may submit claims for any combination of the procedure codes in the group up to the approved quantity.

Communicating Prior Authorization Decisions

ForwardHealth will make a decision regarding a provider's PA request within 20 working days from the receipt of all the necessary information. After processing the PA request, ForwardHealth will send the provider either a decision notice letter or a returned provider review letter. Providers will receive a decision notice letter for PA requests that were approved, approved with modifications, or denied. Providers will receive a returned provider review letter for PA requests that require corrections or additional information. The decision notice letter or returned provider review letter will clearly indicate what is approved or what correction or additional information ForwardHealth needs to continue adjudicating the PA request.

Providers submitting PA requests via the ForwardHealth Portal will receive a decision notice letter or returned provider review letter via the Portal.

If the provider submitted a PA request via mail or fax and the provider has a Portal account, the decision notice letter or returned provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper PA request via mail or fax and does not have a Portal account, the decision notice letter or returned provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), *not* to the address the provider wrote on the PA request.

The decision notice letter or returned provider review letter will not be faxed back to providers who submitted their paper PA request via fax. Providers who submitted their paper PA request via fax will receive the decision notice letter or returned provider letter via mail.

Correcting Returned Prior Authorization Requests and Request Amendments on the Portal

If a provider received a returned provider review letter or an amendment provider review letter, he or she will be able to correct the errors identified on the returned provider review letter directly on the ForwardHealth Portal. Once the provider has corrected the error(s), the provider can resubmit the PA request or amendment request via the Portal to ForwardHealth for processing.

Decision Notice Letters and Returned Provider Review Letters on the Portal

Providers can view PA decision notices and provider review letters via the secure area of the ForwardHealth Portal. Prior authorization decision notices and provider review letters can be viewed when the PA is selected on the Portal.

Note: The PA decision notice or the provider review letter will not be available until the day after the PA request is processed by ForwardHealth.

Denied Requests

When a PA request is denied, both the provider and the member are notified. The provider receives a PA decision notice, including the reason for PA denial. The member receives a Notice of Appeal Rights letter that includes a brief statement of the reason PA was denied and information about his or her right to a fair hearing. Only the *member, or authorized person acting on behalf of the member*, can appeal the denial.

Providers may call Provider Services for clarification of why a PA request was denied.

Providers are required to discuss a denied PA request with the member and are encouraged to help the member understand the reason the PA request was denied.

Providers have three options when a PA request is denied:

- Not provide the service.
- Submit a *new* PA request. Providers are required to submit a copy of the original denied PA request and additional supporting clinical documentation and medical justification along with a new PA/RF, PA/DRF, or PA/HIAS1.
- Provide the service as a noncovered service.

If the member does not appeal the decision to deny the PA request or appeals the decision but the decision is upheld and the member chooses to receive the service anyway, the member may choose to receive the service(s) as a noncovered service.

Modified Requests

Modification is a change in the services originally requested on a PA request. Modifications could include, but are not limited to, either of the following:

- The authorization of a procedure code different than the one originally requested.
- A change in the frequency or intensity of the service requested.

When a PA request is modified, both the provider and the member are notified. The provider will be sent a decision notice letter. The decision notice letter will clearly indicate what is approved or what correction or additional information is needed to continue adjudicating the PA request. The member receives a Notice of Appeal Rights letter that includes a brief statement of the reason PA was modified and information on his or her right to a fair hearing. Only the *member, or authorized person acting on behalf of the member*, can appeal the modification.

Providers are required to discuss with the member the reasons a PA request was modified.

Providers have the following options when a PA request is approved with modification:

- Provide the service as authorized.
- Submit a request to amend the modified PA request. Additional supporting clinical documentation and medical justification must be included.
- Not provide the service.
- Provide the service as originally requested as a noncovered service.

If the member does not appeal the decision to modify the PA request or appeals the decision but the decision is upheld and the member chooses to receive the originally requested service anyway, the member may choose to receive the service(s) as a noncovered service.

Providers may call Provider Services for clarification of why a PA request was modified.

Returned Provider Review Letter Response Time

Thirty Days to Respond to the Returned Provider Review Letter

ForwardHealth must receive the provider's response within 30 calendar days of the date on the returned provider review letter, whether the letter was sent to the provider by mail or through the ForwardHealth Portal. If the provider's response is received within 30 calendar days, ForwardHealth still considers the original receipt date on the PA request when authorizing a grant date for the PA.

If ForwardHealth does not receive the provider's response within 30 calendar days of the date the returned provider review letter was sent, the PA status becomes inactive and the provider is required to submit a new PA request. This results in a later grant date if the PA request is approved. Providers will not be notified when their PA request status changes to inactive, but this information will be available on the Portal and through WiCall.

If ForwardHealth receives additional information from the provider after the 30-day deadline has passed, a letter will be sent to the provider stating that the PA request is inactive and the provider is required to submit a new PA request.

Returned Requests

A PA request may be returned to the provider when forms are incomplete, inaccurate, or additional clinical information or corrections are needed. When this occurs, the provider will be sent a provider review letter.

Returned Provider Review Letter

The returned provider review letter will indicate the PA number assigned to the request and will specify corrections or additional information needed on the PA request. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct PAs that have been placed in returned provider review status in the ForwardHealth Portal.

The provider's paper documents submitted with the PA request will not be returned to the provider when corrections or additional information are needed; however, X-rays, photographs, and dental molds will be returned once the PA is finalized for dentists, physicians, and DME providers. Therefore, providers are required to make a copy of their PA requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if more information is required about the PA request.

Note: When changing or correcting the PA request, providers are reminded to revise or update the documentation retained in their records.

Emergent and Urgent Situations

Emergency Services

In emergency situations, the PA requirement may be waived for services that normally require PA. Emergency services are defined in DHS 101.03(52), Wis. Admin. Code, as "those services which are necessary to prevent the death or serious impairment of the health of the individual."

Reimbursement is not guaranteed for services that normally require PA that are provided in emergency situations. As with all covered services, emergency services must meet all program requirements, including medical necessity, to be reimbursed by Wisconsin Medicaid. For example, reimbursement is contingent on, but not limited to, eligibility of the member, the circumstances of the emergency, and the medical necessity of the services provided.

Wisconsin Medicaid will not reimburse providers for noncovered services provided in any situation, including emergency situations.

Urgent Services

Telephone consultations with DHCAA staff regarding a prospective PA request can be given only in urgent situations when medically necessary. An urgent, medically necessary situation is one where a delay in authorization would result in undue hardship for the member or unnecessary costs for Medicaid as determined by the DHCAA. All telephone consultations for urgent services should be directed to the DHCAA's Bureau of Program Integrity at (608) 266-2521. Providers should have the following information ready when calling:

- Member's name.
- Member identification number.
- Service(s) needed.
- Reason for the urgency.
- Diagnosis of the member.
- Procedure code of the service(s) requested.

Providers are required to submit a PA request to ForwardHealth within 14 calendar days after the date of the telephone consultation. PA may be denied if the request is received more than two weeks after the consultation. If the PA request is denied in this case, the provider cannot request payment from the member.

Follow-Up to Decisions

Amendment Decisions

ForwardHealth will make a decision regarding a provider's amendment request within 20 working days from the receipt of all the information necessary. If the provider submitted the amendment request via the ForwardHealth Portal, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal.

If the provider submitted an amendment request via mail or fax and the provider has a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper amendment request via mail or fax and does not have a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), *not* to the address the provider wrote on the amendment request.

Neither the decision notice letter nor the returned amendment provider review letter will be faxed back to providers who submitted their paper amendment request via fax. Providers who submitted their paper amendment request via fax will receive the decision notice letter or returned amendment provider review letter via mail.

Amendments

Providers are required to use the Prior Authorization Amendment Request to amend an approved or modified PA request.

ForwardHealth does not accept a paper amendment request submitted on anything other than the Prior Authorization Amendment Request. The Prior Authorization Amendment Request may be submitted through the ForwardHealth Portal as well as by mail or fax. If ForwardHealth receives a PA amendment on a previous version of the Prior Authorization Amendment Request form, a letter will be sent to the provider stating that the provider is required to submit a new PA amendment request using the proper forms.

Examples of when providers may request an amendment to an approved or modified PA request include the following:

- To temporarily modify a member's frequency of a service when there is a short-term change in his or her medical condition.
- To change the rendering provider information when the billing provider remains the same.
- To change the ForwardHealth Member Identification Number.
- To add or change a procedure code.

*Note:*ForwardHealth recommends that, under most circumstances, providers should enddate the current PA request and submit a new one if there is a significant, long-term change in services required.

Amendments

Under certain circumstances, providers may amend an approved or modified PA. A request to amend a PA request may be submitted by fax or mail to ForwardHealth and must be received by ForwardHealth *before* the expiration date of the PA request to be amended.

Examples of these types of circumstances include, but are not limited to, the following:

- The Member Identification Number changes.
- There is a short-term change in the member's medical condition and the frequency of a service needs to be modified temporarily, regardless of whether it is an increase or decrease in level of care or hours. Physician orders that reflect the change are required.
- A provider reduces the number of hours of service because another provider begins to share the case. Requests for additional services by another provider may be denied if the number of services on the first PA is not reduced at the same time.
- To add or change a procedure code.
- To change the rendering provider information when the billing provider remains the same.

Providers may also submit a reconsideration request in the form of an amendment when a PA has been modified. Request reconsideration

by submitting a Prior Authorization Amendment Request with additional documentation that supports the original request. The amendment request should be received within 14 calendar days of the adjudication date on the original PA/RF or amendment. If the amendment request is approved, ForwardHealth will notify the provider of the effective date.

An amendment to an approved PA/RF must be requested any time the physician orders additional care, unless the additional services can be billed without a PA number and charged against one of the 30 outstanding PA threshold visits. This includes intermittent additional care due to fluctuations in the availability of the primary caregiver.

A new PA/RF must be submitted when changing requested nursing services from home health skilled nursing or home health aide to PDN or vice versa. Do *not* submit an amendment in these circumstances.

Note: If there is a significant, long-term change that requires a new POC, then ForwardHealth recommends that providers enddate the curre and submit a new request for PA.

The amendment request should include:

- A completed Prior Authorization Amendment Request describing the specific change requested and the reason for the request. Provide sufficient detail for ForwardHealth to determine the medical necessity of the requested services.
- A *copy* of the PA/RF to be amended (*not* a new PA/RF).
- A copy of the updated PA/HCA, member's POC in another format that contains *all* of the components requested in the PA/HCA Completion Instructions, or the physician's orders. If current orders continue to be compatible with the new request, new orders are not necessary.
- Additional supporting materials or medical documentation explaining or justifying the requested changes.

Appeals

If a PA request is denied or modified by ForwardHealth, only a member, or authorized person acting on behalf of the member, may file an appeal with the DHA. Decisions that may be appealed include the following:

- Denial or modification of a PA request.
- Denial of a retroactive authorization for a service.

The member is required to file an appeal within 45 days of the date of the Notice of Appeal Rights letter.

To file an appeal, members may complete and submit a Request for Fair Hearing form.

Though providers cannot file an appeal, they are encouraged to remain in contact with the member during the appeal process. Providers may offer the member information necessary to file an appeal and help present his or her case during a fair hearing.

Fair Hearing Upholds ForwardHealth's Decision

If the hearing decision upholds the decision to deny or modify a PA request, the DHA notifies the member and ForwardHealth in writing. The member may choose to receive the service (or in the case of a modified PA request, the originally requested service) as a noncovered service, not receive the service at all, or appeal the decision.

Fair Hearing Overturns ForwardHealth's Decision

If the hearing decision overturns the decision to deny or modify the PA request, the DHA notifies ForwardHealth, the member, and the provider. The letter includes instructions for the provider and for ForwardHealth.

If the DHA letter instructs the provider to submit a claim for the service, the provider should submit the following to ForwardHealth after the service(s) has been performed:

- A paper claim with "HEARING DECISION ATTACHED" written in red ink at the top of the claim.
- A copy of the hearing decision.
- A copy of the denied PA request.

Providers are required to submit claims with hearing decisions to the following address:

ForwardHealth
Specialized Research
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

Claims with hearing decisions sent to any other address may not be processed appropriately.

If the DHA letter instructs the provider to submit a new PA request, the provider is required to submit the *new* PA request along with a copy of the hearing decision to the PA Unit at the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

ForwardHealth will then approve the PA request with the revised process date. The provider may then submit a claim following the usual claims submission procedures after providing the service(s).

Financial Responsibility

If the member asks to receive the service *before* the hearing decision is made, the provider is required to notify the member before rendering the service that the member will be responsible for payment if the decision to deny or modify the PA request is upheld.

If the member accepts responsibility for payment of the service before the hearing decision is made, and if the appeal decision *upholds* the decision to deny or modify the PA request, the provider may collect payment from the member if certain conditions are met.

If the member accepts responsibility for payment of the service before the hearing decision is made, and if the appeal decision *overturns* the decision to deny or modify a PA request, the provider may submit a claim to ForwardHealth. If the provider collects payment from the member for the service before the appeal decision is overturned, the provider is required to refund the member for the *entire* amount of payment received from the member after the provider receives Medicaid's reimbursement.

Wisconsin Medicaid does not directly reimburse member.

Enddating

Providers are required to use the Prior Authorization Amendment Request to enddate most PA requests. ForwardHealth does not accept requests to enddate a PA request for any service, except drugs, on anything other than the Prior Authorization Amendment Request. PA for drugs may be enddated by using STAT-PA in addition to submitting a Prior Authorization Amendment Request.

Providers may submit a Prior Authorization Amendment Request on the ForwardHealth Portal, or by fax or mail.

If a request to enddate a PA is not submitted on the Prior Authorization Amendment Request, a letter will be sent to the provider stating that the provider is required to submit the request using the proper forms.

Examples of when a PA request should be enddated include the following:

- A member chooses to discontinue receiving prior authorized services.
- A provider chooses to discontinue delivering prior authorized services.

Examples of when a PA request should be enddated and a new PA request should be submitted include the following:

- There is an interruption in a member's continual care services.
- There is a change in the member's condition that warrants a long-term change in services required.
- The service(s) is no longer medically necessary.

Returned Amendment Provider Review Letter

If the amendment request needs correction or additional information, a returned amendment provider review letter will be sent. The letter will show how the PA appears currently in the system and providers are required to respond by correcting errors identified on the letter. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct an amendment request that has been placed in returned provider review status in the ForwardHealth Portal.

ForwardHealth must receive the provider's response within 30 calendar days of the date the returned amendment provider review letter was sent. After 30 days the amendment request status becomes inactive and the provider is required to submit a new amendment request. The ForwardHealth interChange system will continue to use the original approved PA request for processing claims.

The provider's paper documents submitted with the amendment request will not be returned to the provider when corrections or additional information are needed; however, X-rays, photographs, and dental models will be returned once the amendment request is finalized for dentists, physicians, and DME providers. Therefore, providers are required to make a copy of their amendment requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the amendment request.

Note: When changing or correcting the amendment request, providers are reminded to revise or update the documentation retained in their records.

Searching for Previously Submitted Prior Authorization Requests on the Portal

Providers will be able to search for all previously submitted PA requests, regardless of how the PA was initially submitted. If the provider knows the PA number, he or she can enter the number to retrieve the PA information. If the provider does not know the PA number, he or she can search for a PA by entering information in one or more of the following fields:

- Member identification number.
- Requested start date.
- Prior authorization status.
- Amendment status.

If the provider does not search by any of the information above, providers will retrieve all their PA requests submitted to ForwardHealth.

Forms and Attachments

An Overview

Depending on the service being requested, most PA requests must be comprised of the following:

- The PA/RF, PA/DRF, or PA/HIAS1.
- A service-specific PA attachment(s).
- Additional supporting clinical documentation.

Attachments

In addition to the PA/RF, PA/HIAS1, or PA/DRF, a service-specific PA attachment must be submitted with each PA request. The PA attachment allows a provider to document the clinical information used to determine whether or not the standards of medical necessity are met for the requested service(s). Providers should include adequate information for ForwardHealth to make a reasonable judgment about the case.

ForwardHealth will scan each form with a barcode as it is received, which will allow greater efficiencies for processing PA requests.

Documentation Requirements - Home Health Skilled Nursing and Aides

Providers requesting PA for home health skilled nursing and home health aide services are required to include the PA/RF and either the PA/HCA or the member's POC in another format that contains *all* of the components requested in the PA/HCA Completion Instructions.

Providers are required to indicate the expected number of initial and subsequent visits per day, the number of days per week, and the number of weeks or months of service per service type on the PA/RF. The total number of visits requested per week on the PA/RF must match the number of weekly visits indicated on the POC. Services by another provider, whether another home health agency, NIP, or volunteer, must be indicated on the POC.

Documentation Requirements - Home Health Therapy

Providers requesting PA for home health therapy services are required to include the following with the PA/RF:

- The PA/HHTA.
- The therapy POC.
- The therapy evaluation.
- The Individualized Family Service Plan (for children under three years of age enrolled in the Birth to 3 Program).
- The IEP (for school-age children between three and 21 years of age).

Providers are required to indicate the expected number of OT visits, PT visits, and SLP visits per day, the number of days per week, and the number of weeks or months of service per discipline on the PA/RF. The total number of visits requested must exactly match the number of visits indicated on the therapy evaluation and/or the POC.

Providers requesting PA both for home health therapy services and other home health services are only required to submit a single PA/RF for all services.

Providers may refer to a sample PA/HHTA.

Required Prior Authorization Request Information

PA requests for home health therapy services must contain the following information, or the request will be returned to the provider:

- Reason for the referral.
- Diagnoses, including dates of onset.
- Character of the illness — acute, subacute, or chronic.
- Previous therapy — dates, frequency, amount, and types.
- Evaluations with respect to age, problems to be treated, and potential for achieving stated goals.
- Re-evaluations appropriate to progress.
- Rehabilitation potential — history including previous level of functioning, plan for discharge (i.e., from therapy, from group home to apartment), plans for maintenance, member's motivation and cooperation with home health therapy plan, and potential for meeting realistic goals pertaining to functional status.
- Report of home health therapy treatment progress in specific objective and measurable terms.
- Documentation regarding carryover or follow through by the member and/or care giver.

Home Health Therapy Services for School-Age Children

If home health therapy is being requested for a school-age child (between ages 3 and 21 years old), an IEP must be submitted with the PA/RF. If the child is not receiving therapy services according to an IEP, documentation regarding the reasons for the absence of an IEP must be submitted in the PA request. The date of the IEP must be no earlier than 12 months prior to its receipt by ForwardHealth.

Cotreatment

If two providers request cotreatment for one member, each provider is required to complete a separate PA request and submit them together. In addition to completion of PA requirements, the following information must also be included:

- A specific request for cotreatment.
- Identification of the other provider and therapy discipline.
- Documentation verifying the following:
  - Individual treatment from a single PT, OT, or SLP provider does not provide maximum benefit to the member.
  - Two different therapy disciplines are required to *simultaneously* treat the member.

Documentation Requirements - Medication Management

Providers requesting PA for medication management services are required to include the PA/RF and either the PA/HCA or the member's POC in another format that contains *all* of the components requested in the PA/HCA Completion Instructions.

Providers are required to indicate the expected number of visits per week and the number of weeks or months of service on the PA/RF. The total number of visits requested per week on the PA/RF must exactly match the number of weekly visits indicated on the POC. Services by another provider, whether another home health agency, NIP, or volunteer, must be indicated on the POC.

Documentation Requirements - Private Duty Nursing

Providers requesting PA for PDN services are required to include the following with the PA/RF:

- The Private Duty Nursing Prior Authorization Acknowledgment.
- Either the PA/HCA *or* the member's POC in another format that contains *all* of the components requested in the PA/HCA Completion Instructions.

Private Duty Nursing Prior Authorization Acknowledgment

Agencies are required to submit a completed and signed Private Duty Nursing Prior Authorization Acknowledgment with all PA requests for PDN services. This form acknowledges that the member or the member's legal representative has read the POC and PA request.

Documenting Expected Hours on the Prior Authorization Request Form

Providers are required to indicate the expected number of PDN hours for both RNs and LPNs per day, the number of days per week, and

the number of weeks or months of service per provider on the PA/RF. The total number of PDN hours requested on the PA/RF must match the number of hours indicated on the POC. Services by another provider, whether another home health agency, NIP, or volunteer, must also be indicated on the POC.

Documentation Requirements for All Services

In addition to the PA/RF, providers are required to submit the attachments listed in the following table for each type of home care service.

Home Care Service Type	Prior Authorization Forms Required by Wisconsin Medicaid
Home Health Skilled Nursing	PA/RF. PA/HCA **OR** the member's POC in another format that contains *all* of the components requested in the PA/HCA Completion Instructions.
Home Health Aide	PA/RF. PA/HCA **OR** the member's POC in another format that contains *all* of the components requested in the PA/HCA Completion Instructions.
Private Duty Nursing	PA/RF. PA/HCA **OR** the member's POC in another format that contains *all* of the components requested in the PA/HCA Completion Instructions. Private Duty Nursing Prior Authorization Acknowledgment.
Private Duty Nursing for Ventilator-Dependent Members	PA/RF. PA/HCA **OR** the member's POC in another format that contains *all* of the components requested in the PA/HCA Completion Instructions. Private Duty Nursing Prior Authorization Acknowledgment.
Home Health Therapy	PA/RF. PA/HHTA. Therapy POC. Therapy evaluation. Individualized Family Service Plan (for children under three years of age). Individualized Education Plan (for school-aged children between three and 21 years of age).

Obtaining Forms and Attachments

Providers may obtain paper versions of all PA forms and attachments. In addition, providers may download and complete most PA attachments from the ForwardHealth Portal.

Paper Forms

Paper versions of all PA forms and PA attachments are available by writing to ForwardHealth. Include a return address, the name of the form, the form number (if applicable), and mail the request to the following address:

ForwardHealth
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

Providers may also call Provider Services to order paper copies of forms.

Downloadable Forms

Most PA attachments can be downloaded and printed in their original format from the Portal. Many forms are available in fillable PDF and fillable Microsoft® Word formats.

Web Prior Authorization Via the Portal

Certain providers may complete the PA/RF and PA attachments through the Portal. Providers may then print the PA/RF (and in some cases the PA attachment), and send the PA/RF, service-specific PA attachments, and any supporting documentation on paper by mail or fax to ForwardHealth.

Prior Authorization Request Form

The PA/RF is used by ForwardHealth and is mandatory for most providers when requesting PA. The PA/RF serves as the cover page of a PA request.

Providers are required to complete the basic provider, member, and service information on the PA/RF. Each PA request is assigned a unique ten-digit number. ForwardHealth remittance information will report to the provider the PA number used to process claim for prior authorized services.

Prior Authorization Request Form Completion Instructions for Home Health Services

The following sample PA/RFs for home health services are available:

- Sample PA/RF for home health skilled nursing and home health aide services.
- Sample PA/RF for home health skilled nursing requesting PRN visits.
- Sample PA/RF for PDN ventilator-dependent member services.
- Sample PA/RF for PDN for home health therapy services.

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing PA requests, or processing provider claims for reimbursement. The use of the PA/RF is mandatory to receive PA for certain items. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests, along with the PA/HCA or the PA/HHTA, by fax or by mail.

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — HealthCheck "Other Services" and Wisconsin Chronic Disease Program (WCDP)
Enter an "X" in the box next to HealthCheck "Other Services" if the services requested on the PA/RF are for HealthCheck "Other Services." Enter an "X" in the box next to WCDP if the services requested on the PA/RF are for a WCDP member.

Element 2 — Process Type
Enter process type 120 for home health services. The process type is a three-digit code used to identify a category of service requested. Prior authorization requests will be returned without adjudication if no process type is indicated.

Element 3 — Telephone Number — Billing Provider
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 4 — Name and Address — Billing Provider
Enter the name and complete address (street, city, state, and ZIP+4 code) of the billing provider. Providers are required to include both the ZIP code and the four-digit extension for timely and accurate billing. The name listed in this element must correspond with the billing provider number listed in Element 5a.

Element 5a — Billing Provider Number
Enter the NPI of the billing provider. The NPI in this element must correspond with the provider name listed in Element 4.

Element 5b — Billing Provider Taxonomy Code
Enter the national 10-digit alphanumeric taxonomy code that corresponds to the NPI of the billing provider in Element 5a.

SECTION II — MEMBER INFORMATION

Element 6 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or Wisconsin's EVS to obtain the correct number.

Element 7 —Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

Element 8 — Address — Member
Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code. If the member is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 9 — Name — Member
Enter the member's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 10 — Gender — Member
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 11 — Diagnosis — Primary Code and Description
Enter the appropriate ICD-9-CM diagnosis code and description most relevant to the service/procedure requested.

Element 12 — Start Date — SOI (not required)

Element 13 — First Date of Treatment — SOI (not required)

Element 14 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Element 15 — Requested PA Start Date
Enter the requested start date for service(s) in MM/DD/CCYY format, if a specific start date is requested.

Element 16 — Rendering Provider Number (not required)

Element 17 — Rendering Provider Taxonomy Code (not required)

Element 18 — Procedure Code
Enter the appropriate CPT code or HCPCS procedure code for each service/procedure requested.

Element 19 — Modifiers
Enter the modifier(s) corresponding to the service code listed if a modifier is required.

Element 20 — POS
Enter POS code "12." The member's home is the only allowable POS.

Element 21 — Description of Service
Enter a written description corresponding to the appropriate procedure code for service/procedure requested. Indicate in the description the credentials of the individual who provided the service (e.g., licensed practical nurse, registered nurse).

When requesting home health skilled nursing, home health aide, or home health therapy services, indicate the number of visits per day, multiplied by the number of days per week, multiplied by the total number of weeks being requested.

When requesting PDN services, indicate the number of hours per day, multiplied by the number of days per week, multiplied by the total number of weeks being requested.

If sharing a case with another provider, enter "shared case" and include a statement that the total number of hours of all providers will not

exceed the combined total number of hours ordered on the physician's POC. When requesting two procedure codes to be used interchangeably, include a statement that the total number of hours will not exceed the combined total number of hours ordered on the physician's POC. When requesting permission to bill for multiple visits when only one visit is provided, enter "Authorization requested to bill for (number of) subsequent Home Health Aide visits to do (number of) continuous hours of care."

Element 22 — QR
Enter the appropriate quantity (e.g., number of services, days' supply) requested for the procedure code listed.

Element 23 — Charge
Enter the provider's usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to provider *Terms of Reimbursement* issued by the DHS.

Element 24 — Total Charges
Enter the anticipated total charges for this request.

Element 25 — Signature — Requesting Provider
The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 26 — Date Signed
Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

Supporting Clinical Documentation

Certain PA requests may require additional supporting clinical documentation to justify the medical necessity for a service(s). Supporting documentation may include, but is not limited to, X-rays, photographs, a physician's prescription, clinical reports, and other materials related to the member's condition.

All supporting documentation submitted with a PA request must be clearly labeled and identified with the member's name and member identification number. Securely packaged X-rays and photographs will be returned to providers with the finalized PA request. X-rays and photographs must be mailed with the PA request. Mailing dental models with PA requests is recommended.

General Information

An Overview

The PA review process continues to include both a clerical review and a clinical review. The PA request will have one of the statuses detailed in the following table.

Prior Authorization Status	Description
Approved	The PA request was approved.
Approved with Modifications	The PA request was approved with modifications to what was requested.
Denied	The PA request was denied.
Returned — Provider Review	The PA request was returned to the provider for correction or for additional information.
Pending — Fiscal Agent Review	The PA request is being reviewed by the Fiscal Agent.
Pending — Dental Follow-up	The PA request is being reviewed by a Fiscal Agent dental specialist.
Pending — State Review	The PA request is being reviewed by the State.
Suspend — Provider Sending Information	The PA request was submitted via the ForwardHealth Portal and the provider indicated they will be sending additional supporting information on paper.
Inactive	The PA request is inactive due to no response within 30 days to the returned provider review letter and cannot be used for PA or claims processing.

Communication with Members

ForwardHealth recommends that providers inform members that PA is required for certain specified services *before* delivery of the services. Providers should also explain that, if required to obtain PA, they will be submitting member records and information to ForwardHealth on the member's behalf. Providers are required to keep members informed of the PA request status throughout the *entire* PA process.

Member Questions

A member may call Member Services to find out whether or not a PA request has been submitted and, if so, when it was received by ForwardHealth. The member will be advised to contact the provider if more information is needed about the status of an individual PA request.

Definition

PA is the electronic or written authorization issued by ForwardHealth to a provider prior to the provision of a service. In most cases, providers are required to obtain PA *before* providing services that require PA. When granted, a PA request is approved for a specific period of time and specifies the type and quantity of service allowed.

PA requests may be submitted no earlier than 62 days prior to the requested effective date.

Designating an Address for Prior Authorization Correspondence

Correspondence related to PA will be sent to the practice location address on file with ForwardHealth unless the provider designates a separate address for receipt of PA correspondence. This policy applies to all PA correspondence, including decision notice letters, returned provider review letters, returned amendment provider letters, and returned supplemental documentation such as X-rays and photographs.

Providers who want to designate a separate address for PA correspondence have the following options:

- Update demographic information online via the ForwardHealth Portal. (This option is only available to providers who have established a provider account on the Portal.)
- Submit a Provider Change of Address or Status form.

Disposable Medical Supplies

Refer to the DMS Index and the DMS area of the Online Handbook for information on requesting PA for DMS.

Durable Medical Equipment

Refer to the DME Index and the DME area of the Online Handbook for information on requesting PA for DME.

Members with Changing Nursing Needs

Nursing services may be billed as home health skilled nursing services for a maximum of 30 calendar days. The 30-day grace period is provided to allow the provider time to submit a new PA/RF for PDN services. The 30 days begin accumulating on the first day that eight hours or more of direct, skilled nursing services become necessary. The 30-day grace period may not be used for providing any nursing services outside the member's home.

This 30-day period is the only time that services for a member requiring eight or more hours of direct, skilled nursing care per calendar day may be billed as home health skilled nursing services.

After the 30-day grace period has ended, home health skilled nursing services are no longer reimbursable for a member receiving eight hours or more of direct, skilled nursing services. If PA for PDN services has not been approved by the end of the 30-day grace period, only home health skilled nursing services of less than eight hours as approved on the current PA/RF will be reimbursable.

Members Who No Longer Require Private Duty Nursing

If the condition of a member receiving PDN services improves to the point that less than eight hours of direct, skilled nursing care are required in a calendar day, the member is no longer eligible for PDN. An alternate level of care such as intermittent skilled nursing visits, home health aide visits, or personal care services may be more appropriate.

Other Members of a Member's Household

ForwardHealth encourages other members of a member's household to participate in providing care to the member. However, this participation is not a condition of coverage.

With the permission of the member or the member's legal representative, the provider should ask members of the household about the extent they are able and willing to provide medically necessary covered services for the member. If household members are not willing or able to provide care, the nurse should document the reasons why in the member's medical record. A Community Options Program assessment or narrative reflecting possible informal support systems meets this requirement.

When medically necessary covered services that are normally furnished by the provider are instead provided by willing and able household members, these services cannot be billed to ForwardHealth.

Personal Care Services

If the member is receiving both personal care services and home health services from the home health agency, the agency must request PA for the home health and personal care services on the same PA/RF. Services added during the term of the PA/RF must be added by amendment. Providers should refer to the Personal Care section of the Online Handbook for further information about personal care services.

Prior Authorization Numbers

Upon receipt of the PA/RF, ForwardHealth will assign a PA number to each PA request.

The PA number consists of 10 digits, containing valuable information about the PA (e.g., the date the PA request was received by ForwardHealth, the medium used to submit the PA request).

Each PA request is assigned a unique PA number. This number identifies valuable information about the PA. The following diagram and table provides detailed information about interpreting the PA number.

Type of Number and Description	Applicable Numbers and Description
Media — One digit indicates media type.	Digits are identified as follows: 1= paper; 2 = fax; 3 = STAT-PA; 4 = STAT-PA; 5 = Portal; 6 = Portal; 7 = NCPDP transaction
Year — Two digits indicate the year ForwardHealth received the PA request.	For example, the year 2008 would appear as 08.
Julian date — Three digits indicate the day of the year, by Julian date, that ForwardHealth received the PA request.	For example, February 3 would appear as 034.
Sequence number — Four digits indicate the sequence number.	The sequence number is used internally by ForwardHealth.

Reasons for Prior Authorization

Only about four percent of all services covered by Wisconsin Medicaid require PA. PA requirements vary for different types of services. Refer to ForwardHealth publications and DHS 107, Wis. Admin. Code, for information regarding services that require PA. According to DHS 107.02(3)(b), Wis. Admin. Code, PA is designed to do the following:

- Safeguard against unnecessary or inappropriate care and services.
- Safeguard against excess payments.
- Assess the quality and timeliness of services.
- Promote the most effective and appropriate use of available services and facilities.
- Determine if less expensive alternative care, services, or supplies are permissible.
- Curtail misutilization practices of providers and members.

PA requests are processed based on criteria established by the DHS.

Providers should not request PA for services that do not require PA simply to determine coverage or establish a reimbursement rate for a manually priced procedure code. Also, new technologies or procedures do not necessarily require PA. PA requests for services that do not require PA are typically returned to the provider. Providers having difficulties determining whether or not a service requires PA may call Provider Services.

Referrals to Out-of-State Providers

PA may be granted to non-certified out-of-state providers when nonemergency services are necessary to help a member attain or regain his or her health and ability to function independently. The PA request may be approved only when the services are not reasonably accessible to the member in Wisconsin.

Out-of-state providers are required to meet Wisconsin Medicaid's guidelines for PA approval. This includes sending PA requests, required attachments, and supporting documentation to ForwardHealth before the services are provided.

Note: Emergency services provided out-of-state do not require PA; however, claims for such services must include appropriate documentation (e.g., anesthesia report, medical record) to be considered for reimbursement. Providers are required to submit claims with supporting documentation on paper.

When a Wisconsin Medicaid provider refers a member to an out-of-state, non-certified provider, the referring provider should refer the out-

of-state provider to the ForwardHealth Portal or Provider Services to obtain appropriate certification materials, PA forms, and claim instructions.

All out-of-state nursing homes, regardless of location, are required to obtain PA for all services. All other out-of-state non-border-status providers are required to obtain PA for all nonemergency services except for home dialysis supplies and equipment.

Reimbursement Not Guaranteed

Wisconsin Medicaid may decline to reimburse a provider for a service that has been prior authorized if one or more of the following program requirements is not met:

- The service authorized on the approved PA request is the service provided.
- The service is provided within the grant and expiration dates on the approved PA request.
- The member is eligible for the service on the date the service is provided.
- The provider is certified by Wisconsin Medicaid on the date the service is provided.
- The service is billed according to service-specific claim instructions.
- The provider failed to meet other program requirements.

Providers may not collect payment from a member for a service requiring PA under any of the following circumstances:

- The provider failed to seek PA before the service was provided.
- The service was provided before the PA grant date or after the PA expiration date.
- The provider obtained PA but failed to meet other program requirements.
- The service was provided before a decision was made, the member did not accept responsibility for the payment of the service before the service was provided, and the PA was denied.

There are certain situations when a provider may collect payment for services in which PA was denied.

Other Health Insurance Sources

Providers are encouraged, but not required, to request PA from ForwardHealth for covered services that require PA when members have other health insurance coverage. This is to allow payment by Wisconsin Medicaid for the services provided in the event that the other health insurance source denies or recoups payment for the service. If a service is provided before PA is obtained, ForwardHealth will not consider backdating a PA request solely to enable the provider to be reimbursed.

Services Requiring Prior Authorization

Wisconsin Medicaid requires PA for the following services provided by home health agencies:

- All home health skilled nursing, medication management, home health aide, and home health therapy visits by all providers after the first 30 visits in a calendar year.
- Visits made by *all* providers from the home health agency accumulate toward the 30-visit threshold. After the first 30 visits, if one provider in a shared case requires PA, all providers on that case are required to have PA.
- All PDN services as stated in DHS 107.12(2)(a), Wis. Admin. Code.
- All home health and PCW services that are provided in conjunction with PDN services.
- All home health services provided by NIP.

Wisconsin Medicaid does not reimburse these services if they are provided:

- Without an approved PA.
- Before the grant date on the PA/RF.
- After the expiration date on the PA/RF.

PA does not guarantee reimbursement. Provider eligibility, member enrollment, and medical status on the DOS, as well as all other Medicaid requirements, must be met before the claim is paid.

Sources of Information

Providers should verify that they have the most current sources of information regarding PA. It is critical that providers and staff have access to these documents:

- Wisconsin Administrative Code: Chapters DHS 101 through DHS 109 are the rules regarding Medicaid administration.
- Wisconsin Statutes: Sections 49.43 through 49.99 provide the legal framework for Wisconsin Medicaid.
- ForwardHealth Portal: The Portal gives the latest policy information for all providers, including information about Medicaid managed care enrollees.

Status Inquiries

Providers may inquire about the status of a PA request through one of the following methods:

- Accessing WiCall, ForwardHealth's AVR system.
- Calling Provider Services.

Providers should have the 10-digit PA number available when making inquiries.

Two Caregivers Providing Care for a Member at the Same Time

When it is medically necessary and PA has been obtained, Wisconsin Medicaid may reimburse for a PCW to assist an RN, LPN, home health aide, or another PCW. If two providers are caring for a member simultaneously, one provider must be a PCW. The situations in which a PCW may assist are:

- Periodic changing of the entire tracheostomy tube.
- Periodic transfer or repositioning of a member when a two-person transfer is required to assure safety because all other transfer devices have failed.

The provider is required to document on the POC the reason that two caregivers are required.

Grant and Expiration Dates

Backdating

Backdating an initial PA request to a date prior to ForwardHealth's initial receipt of the request may be allowed in limited circumstances.

A request for backdating may be approved if all of the following conditions are met:

- The provider specifically requests backdating in writing on the PA request.
- The request includes clinical justification for beginning the service before PA was granted.
- The request is received by ForwardHealth within 14 calendar days of the start of the provision of services.

Backdating

Backdating a PA request to a date prior to ForwardHealth's initial receipt of the request may be allowed in limited circumstances.

Initial Requests

An initial PA request may be backdated up to 14 calendar days from the first date of receipt by ForwardHealth. For backdating to be authorized, both of the following criteria must be met:

- The provider specifically requests backdating in writing on the PA request.
- The request includes clinical justification for beginning the service before PA was granted.
- The request is received by ForwardHealth within 14 calendar days of the start of the provision of services.

Extraordinary Circumstances

In the following cases, a PA request *may* be backdated for more than 14 days:

- A court order or hearing decision requiring Wisconsin Medicaid coverage is attached to the PA request.
- The member is retroactively enrolled. (Indicate in Element 21 of the PA/RF that the service was provided during a period of member retroactive enrollment. In Element 15, indicate the actual date the service was provided.)

Returned Requests

An initial PA request returned for additional information may be backdated 14 calendar days from the date it was initially received by ForwardHealth if the additional corrected information is returned with the original PA/RF.

Amendment Requests

PA amendment requests may be backdated 14 calendar days from the date of receipt by ForwardHealth if the request is for urgent situations in which medical necessity could not have been predicted.

Amendment requests may also be backdated to the grant date on the original PA request for the following two reasons:

- The amendment request is directly related to a modification of the original request **and** ForwardHealth receives the amendment request within 14 days of the adjudication date on the original PA/RF.
- The amendment request results from an error on the original adjudication.

Denied Requests

Once a PA request has been denied, that PA number can no longer be used. A new PA number must be used with a new request. A new request following a denial may be backdated to the original date the denied request was received by ForwardHealth when all the following

criteria are met:

- The earlier grant date is requested.
- The denied PA request is referred to in writing.
- The new PA request has information to justify approval.
- The request for reconsideration submitted with additional supporting documentation is received within 14 calendar days of the adjudication date on the original denied PA request.

Subsequent Requests Will Not Be Backdated

ForwardHealth will not backdate subsequent PA requests for continuation of ongoing services. To prevent a lapse in coverage, all subsequent PA requests must be received by ForwardHealth prior to the expiration date of the previous PA.

Expiration Date

The expiration (end) date of an approved or modified PA request is the date through which services are prior authorized. PA requests are granted for varying periods of time. Expiration dates may vary and do not automatically expire at the end of the month or calendar year. In addition, providers may request a specific expiration date. Providers should carefully review all approved and modified PA requests and make note of the expiration dates.

Grant Date

The grant (start) date of an approved or modified PA request is the first date in which services are prior authorized and will be reimbursed under this PA number. On a PA request, providers may request a specific date that they intend services to begin. If no grant date is requested or the grant date is illegible, the grant date will typically be the date the PA request was reviewed by ForwardHealth.

Renewal Requests

To prevent a lapse in coverage or reimbursement for ongoing services, all renewal PA requests (i.e., subsequent PA requests for ongoing services) must be received by ForwardHealth *prior to the expiration date* of the previous PA request. Each provider is solely responsible for the timely submission of PA request renewals. Renewal requests will not be backdated for continuation of ongoing services.

Home Health Skilled Nursing, Medication Management, Home Health Aide, and Home Health Therapy

30-Visit Threshold

Standard Plan and Medicaid

A member may receive a total of 30 visits, including home health skilled nursing services, medication management services, home health aide services, and home health therapy services, per calendar year before PA is required. PA is required when the total of any combination of these services per member exceeds 30 visits, regardless of the provider or service.

For example, if a member received 10 home health aide initial visits, five home health aide subsequent visits, five home health skilled nursing initial visits and 10 physical therapy visits, for a total of 30 visits, PA is required before any further services will be reimbursed by Wisconsin Medicaid during the same calendar year.

If the member has received home health services from another provider during the calendar year, those visits are also counted toward the 30-visit threshold.

Although providers are permitted to provide 30 visits without PA in a new calendar year, providers are encouraged to request PA immediately upon completion of the POC so that reimbursement is not jeopardized.

Benchmark Plan

A BadgerCare Plus Benchmark Plan member may receive a total of 30 visits **per enrollment year** before PA is required. PA policy and procedures for home health visits are the same under the Benchmark Plan as they are under the Standard Plan except that PA will not be granted for visits that exceed 60 during the member's enrollment year.

Under the Benchmark Plan, home health agencies do not need PA for home health services up to and including 30 visits during one enrollment year. The 31st visit through the 60th visit require PA.

Even with PA, the Benchmark Plan does not cover over 60 home health visits per enrollment year.

Continuous Visits

Providers may request PA to enable them to bill for multiple home health aide visits. The provider is required to indicate the following on the PA/RF: "Authorization requested to bill for (number of) subsequent HH aide visits due to (number of) continuous hours of care."

Documentation submitted must support the medical necessity of the continuous visits.

In determining the number of continuous home health aide visits PA will be granted for, consideration will be given to the member's needs and special circumstances.

Medication Management

Medication management visits require PA and count toward the 30-visit threshold.

Ongoing Assessments

Ongoing assessments do not require PA and do not count toward the 30-visit threshold.

Pro Re Nata Visits

Providers may request PRN, or "as needed," visits only when service is likely to vary due to changes in the member's need for services. If the use of PRN visits is anticipated, the specific number of PRN visits must be included in the POC and requested by procedure code per week or month of service on the PA/RF as demonstrated in this example. PRN visits must be added to the regularly scheduled number of visits requested for a particular procedure code. The reason for the PRN visits must be explained based on member-centered parameters.

Shared Cases

For each calendar day, there can only be one initial visit for any given procedure code, regardless of the number of providers administering services to the member on that day. Providers with shared cases should coordinate with each other to determine which agency will provide the initial visit. This information must be indicated on the PA/RF. Additional visits for the same procedure code on the same calendar day are classified as subsequent visits.

Providers should verify that requests for PA specify the appropriate number and type of visits to assure consistent member care and proper reimbursement. For this reason, coordination between providers of shared cases is strongly encouraged.

Member Eligibility Changes

Loss of Enrollment During Treatment

Some covered services consist of sequential treatment steps, meaning more than one office visit or service is required to complete treatment.

In most cases, if a member loses enrollment midway through treatment, or at any time between the grant and enddates, Wisconsin Medicaid will *not* reimburse services (including prior authorized services) provided during an enrollment lapse. Providers should not assume Wisconsin Medicaid covers completion of services after the member's enrollment has been terminated.

To avoid potential reimbursement problems when a member loses enrollment during treatment, providers should follow these procedures:

- Ask to see the member's ForwardHealth identification card to verify the member's enrollment or consult Wisconsin's EVS before the services are provided at each visit.
- When the PA request is approved, verify that the member is still enrolled and eligible to receive the service before providing it. An approved PA request does not guarantee payment and is subject to the enrollment of the member.

Members are financially responsible for any services received after their enrollment has ended. If the member wishes to continue treatment, it is a decision between the provider and the member whether the service should be given and how payment will be made for the service.

To avoid misunderstandings, providers should remind members that they are financially responsible for any continued care after their enrollment ends.

Retroactive Disenrollment from State-Contracted MCOs

Occasionally, a service requiring fee-for-service PA is performed during a member's enrollment period in a state-contracted MCO. After the service is provided, and it is determined that the member should be retroactively disenrolled from the MCO, the member's enrollment is changed to fee-for-service for the DOS. The member is continuously eligible for BadgerCare Plus or Wisconsin Medicaid but has moved from MCO enrollment to fee-for-service status.

In this situation, the state-contracted MCO would deny the claim because the member was not enrolled on the DOS. Fee-for-service would also deny the claim because PA was not obtained.

Providers may take the following steps to obtain reimbursement in this situation:

- For a service requiring PA for fee-for-service members, the provider is required to submit a retroactive PA request. For a PA request submitted on paper, indicate "RETROACTIVE FEE-FOR-SERVICE" along with a written description of the service requested/provided under "Description of Service." Also indicate the actual date(s) the service(s) was provided. For a PA request submitted via the ForwardHealth Portal, indicate "RETROACTIVE FEE-FOR-SERVICE" along with a description of the service requested/provided under the "Service Code Description" field or include additional supporting documentation. Also indicate the actual date(s) the service(s) was provided.
- If the PA request is approved, the provider is required to follow fee-for-service policies and procedures for claims submission.
- If the PA request is denied, Wisconsin Medicaid will not reimburse the provider for the services. A PA request would be denied for reasons such as lack of medical necessity. A PA request would not be denied due to the retroactive fee-for-service status of the member.

Retroactive Enrollment

If a service(s) that requires PA was performed during a member's retroactive enrollment period, the provider is required to submit a PA request and receive approval from ForwardHealth *before* submitting a claim. For a PA request submitted on paper, indicate the words "RETROACTIVE ENROLLMENT" at the top of the PA request along with a written description explaining that the service was provided at a time when the member was retroactively enrolled under "Description of Service." Also include the actual date(s) the service(s) was provided. For a PA request submitted via the ForwardHealth Portal, indicate the words "RETROACTIVE ENROLLMENT" along with a description explaining that the service was provided at a time when the member was retroactively eligible under the "Service Code

Description" field or include additional supporting documentation. Also include the actual date(s) the service(s) was provided.

If the member was retroactively enrolled, and the PA request is approved, the service(s) may be reimbursable, and the earliest effective date of the PA request will be the date the member receives retroactive enrollment. If the PA request is denied, the provider will not be reimbursed for the service(s). Members have the right to appeal the decision to deny a PA request.

If a member requests a service that requires PA before his or her retroactive enrollment is determined, the provider should explain to the member that he or she may be liable for the full cost of the service if retroactive enrollment is not granted and the PA request is not approved. This should be documented in the member's record.

Plan of Care

A Comprehensive Overview

Home health services must be provided according to the member's written, signed, and dated POC as defined in DHS 105.16(1), Wis. Admin. Code.

Certification Period

Each certification period may last no longer than 62 days. The 62-day period corresponds with the certification period dates in Element 4 of the PA/HCA and includes both the "From" date and the "To" date. The POC expires at the end of the 62-day certification period. (Medicare-certified agencies should use the time frame of up to, but not more than, *60 days* later.)

All components of the POC are required to be reviewed by a physician at least every 62 days as stated in DHS 105.16(1), Wis. Admin. Code. If multiple physicians order services, orders are combined on one POC and reviewed, signed, and dated by the primary physician at least every 62 days. The home health agency has the responsibility to sign and confirm the date that the information on the POC was reviewed with the physician, to verify that the POC is complete, and to keep a current and complete POC on file.

Once the physician reviews, signs, and dates the POC, it serves as the physician's orders for the length of the certification period.

The physician must review, sign, and date all subsequent POC *prior* to the beginning certification date on the POC. Otherwise, the agency is providing services without orders, and such services will not be reimbursed by Wisconsin Medicaid.

Changes

When the member's medical needs change, the provider is required to notify the physician so that the physician may order a change to the POC to reflect the member's current medical needs.

It is illegal to add or change orders on a POC after it has been signed by a physician. To add or change orders, providers must have on file a signed and dated copy of the new physician orders to the POC. These changes must be incorporated into the next POC, prior to it being signed by the physician.

ForwardHealth will *not* accept correction fluid or correction tape on a POC. When correcting errors on a POC before it is signed, a nurse should cross out the error with a single line and place his or her initials and date next to the correction. ForwardHealth will return a POC with other methods of correction to the provider.

Completing the Plan of Care

As required in Element 24 of the PA/HCA Completion Instructions, the RN *completing* the POC is required to sign the PA/HCA. To *complete* the POC, the RN is required to do all of the following:

- Develop the nursing POC.
- Review the information provided in the POC to assure that all required components are included.
- Review the information provided in the POC to assure that it is correct.

Under ch. N 6.03, Wis. Admin. Code, an RN is responsible for the POC. Under ch. N 6.04, Wis. Admin. Code, an LPN may *assist* with the development and revision of the POC.

Someone other than the RN may key the required components into the document, but the RN signing the PA/HCA takes full responsibility for the contents of the POC.

Developing the Plan of Care

Development of the POC should be based on the orders of a physician, a visit to the member's residence by either an RN or therapist as appropriate, and in consultation with the physician, the member, or, as appropriate, the member's legal representative, the member's family, and other members of the household.

When developing the POC, the provider should also assess the member's social and physical environment, including the following:

- Family involvement.
- Living conditions.
- The member's level of functioning.
- Any pertinent cultural factors.

LPNs may not develop the POC.

Documentation Methods

When completing and submitting the POC, home health providers may use either the PA/HCA or the member's POC in another format that contains *all* of the components requested in the PA/HCA Completion Instructions.

When completed according to the completion instructions, the PA/HCA contains the information required to adjudicate a provider's PA request for home care services.

Each provider should respond to the PA/HCA Completion Instructions consistent with his or her provider type and the services being provided under the POC.

Complete and accurate information is required to adjudicate PA requests submitted for home care services. Incomplete PA requests will be returned to the provider.

Submitting Another Format for the Member's Plan of Care

Providers who choose to submit the member's POC in another format are required to include all of the components requested in the PA/HCA Completion Instructions. PA requests received without the requested information will be returned to the provider.

Providers choosing this option should note that the nurse and physician who sign and date the POC are required to attest to the respective Wisconsin Medicaid certification statements in Section VI of the PA/HCA Completion Instructions.

To speed processing and reduce the number of returned PA requests, providers are strongly encouraged to verify that all requested information is included with the PA request when choosing to submit a version of the POC other than the PA/HCA.

Element 26 of the Prior Authorization/Home Care Attachment

If the nurse signing and dating Elements 24 and 25 of the PA/HCA receives verbal orders from the attending physician to start care for the *initial* certification period, the nurse should enter the date the verbal orders were received in Element 26. If the nurse did not receive verbal orders, Element 26 should be left blank.

Elements 24 and 25 of the Prior Authorization/Home Care Attachment

Regardless of whether the physician's order is for the start of care with the initial certification period or for continuing care with a recertification period, the RN completing the POC is required to sign and date the PA/HCA. By signing and dating the PA/HCA, the RN attests to the following:

- The information contained in the POC is complete and accurate.

- He or she is familiar with all of the information in the POC.
- When providing services, he or she is responsible for ensuring that the POC is carried out as specified.

Elements 24 and 25 must be completed on or before the certification period "From" date indicated in Element 4 of the PA/HCA.

Medical Necessity and the Plan of Care

The member's health status and medical need, as reflected in the POC, provide the basis for determinations as to whether services provided are reasonable and medically necessary.

Each provider is responsible, along with the physician, for the contents of the POC relating to the medical necessity of care, accuracy of all information submitted, and relevance of the POC to the member's current medical condition. Providers are required to do the following:

- Promptly notify the member's physician of any change in the member's condition that suggests a need to modify the POC.
- Implement any changes that were made to the POC.

Providers are required to include a complete, detailed, and accurate description of the member's medical condition and needs in the POC. The POC should be developed and reviewed concurrently and in support of other health care providers providing services to the member in the home.

Physician Signature Extension for Member Plans of Care

ForwardHealth recognizes that Medicare-certified home health agencies can encounter difficulties obtaining a physician's signature for POC recertifications within the time designated by Wisconsin Administrative Code. In response, the DHS has established a process and created a form titled Verbal Orders for Recertification: Home Health Agency Request for Variance of Physician Signature Requirement to expedite requests for a 20 working day extension to obtain the physician's signature. (Working days refer to Monday through Friday.) The variance is limited to verbal orders for POC recertification periods. The variance will increase the time providers have to obtain the physician's signature on a member's POC.

Through the administrative rule-making process effective with the scope statement of August 1, 2003, language has been drafted to address the situation created with the implementation of Medicare changes involving the time frame for collecting OASIS data. Until changes to DHS 105 and DHS 107, Wis. Admin. Code, become effective, the DHS recommends that those agencies use the Verbal Orders for Recertification: Home Health Agency Request for Variance of Physician Signature Requirement form when requesting a variance to the administrative code pertaining to requirements for having the physician review the member's POC and obtaining the physician's dated signature on the member's written POC prior to recertification periods.

Submitting a Variance Request

Only Wisconsin Medicaid-certified home health agencies that are Medicare-certified may submit the Verbal Orders for Recertification: Home Health Agency Request for Variance of Physician Signature Requirement form.

Any branch of a Medicare-certified home health agency that is assigned its own unique provider number must submit a *separate* request form to also receive the variance.

Providers should not submit a request for each member. Only one form per provider number should be submitted.

Obtaining the Physician's Signature

Under the variance, agencies will be required to obtain the physician's signature on the member's written POC before submitting claims for services to ForwardHealth. The physician's signature must be obtained no later than 20 working days following the "From" date listed on the POC for the recertification period. This is also the same date listed as the "From" date in Element 4 of the PA/HCA.

If the home health agency does not obtain the physician's signature as required by the variance, the agency is providing services without written orders, and such services are non-reimbursable as stated in DHS 107.02(2)(f), Wis. Admin. Code. When the physician's dated signature is obtained more than 20 working days after the "From" date listed on the POC for the recertification period, claims for services provided may be reimbursed beginning with the date the agency receives the physician's dated signature on the member's written POC.

Documentation Requirements

The variance is applicable only when the agency has obtained verbal orders and sent the POC to the ordering physician *before* the beginning of the recertification period. The agency must maintain documentation of the date the POC was sent to the ordering physician for his or her signature.

When the POC is prepared, home health agencies are required to include all the components as instructed in the PA/HCA Completion Instructions. The nurse obtaining verbal orders for a recertification period under the variance is required to complete Element 25 as stated in the PA/HCA Completion Instructions after reviewing the POC with the ordering physician. In the context of the instructions for Element 25, the nurse is expected to review the POC with the ordering physician as appropriate to the nurse's license under ch. N 6, Wis. Admin. Code.

Effective Date of Variance

Home health agencies will receive a signed letter from ForwardHealth for their records that includes the effective date and the terms of the discretionary variance.

Unless an agency has received a letter from ForwardHealth granting the variance, the agency is required to comply with the physician signature requirements as stated in Wisconsin Administrative Code or be subject to a potential recovery of any improper payment.

Medicare and Wisconsin Medicaid Certification Requirements

Wisconsin Medicaid requires home health agencies to first be *Medicare* certified before obtaining certification with Wisconsin Medicaid. In addition, an agency is required to maintain *Medicare* certification to continue to be eligible for Wisconsin Medicaid certification.

Medicare requires a home health agency to complete the OASIS between days 55 and 60 of each 60-day certification period. *Wisconsin Medicaid* requires that the home health agency have the POC signed and dated by the physician prior to the continuation of services past the initial 60-day certification period, as stated in ch. DHS 107.11(6)(b)4, 107.113(2), and 107.12(1)(d)2, Wis. Admin. Code.

Because strict enforcement of Wisconsin Administrative Code could result in unreasonable hardship to the home health agency, it is recommended that home health agencies complete the Verbal Orders for Recertification: Home Health Agency Request for Variance of Physician Signature Requirement form to request a 20 working day extension to obtain a physician's signature for verbal orders for POC recertifications.

Physician Stamped Signatures

Under specific conditions, Wisconsin Medicaid accepts physicians' stamped signatures on physician orders and POC, including attachments that are submitted with requests for PA.

The home care provider (NIP, Home Health, Personal Care) is required to meet *both* of the following requirements before accepting a physician's stamped signature:

- Obtain a dated statement from the physician with the physician's original signature attesting that he or she is the only person who possesses the signature stamp and is the only person who uses it.
- Maintain the signed and dated physician statement in the home care provider's records.

Wisconsin Medicaid will consider a stamped signature invalid if these requirements are not met. Payments made by Wisconsin Medicaid to a home care provider that are based on physician orders, authorized PA requests, or POC stamped with an invalid or improperly used signature stamp will be *subject to recoupment*. These requirements are similar to those of CMS for providers participating in Medicare.

Signature Stamp Security Awareness for Physicians

Physicians using a signature stamp should be aware that this method is much less secure than a handwritten signature, creating the potential for misuse or abuse of the stamp. The individual whose name is on the signature stamp is responsible for and attests to the authenticity of the information. Physicians should check with their attorneys and malpractice insurers in regard to the use of a signature stamp.

Physician Verbal Orders

At times, the physician may give an order verbally.

Verbal Orders for Initial Certification

To facilitate immediate access to home care services, Wisconsin Medicaid allows home health agencies to be reimbursed for services provided under verbal orders. The agency is required to reduce the verbal orders to writing, transmit the orders to the physician immediately, and obtain the physician's signature and date on those orders within 20 working days.

Verbal Orders for Subsequent Certification

Once care has started, *verbal orders may not be obtained for subsequent certification periods*. For ongoing cases, the physician must review, sign, and date renewed or (as necessary) revised orders before the end of the certification period for the agency to continue to be reimbursed without interruption after starting care of the member.

Verbal Orders Within Any Certification Period

An *urgent* situation may prompt the physician to issue verbal orders. Such verbal orders *during* the authorized certification period are the direct result of changes in the patient's condition necessitating an immediate modification to the POC. For example, the member's adverse reaction to a currently prescribed medication or treatment may result in a physician verbally ordering a change to the member's treatment or medication.

When verbal orders are necessary within a certification period, the agency must document the orders, reduce them to writing, and sign and date them. The agency has 10 days from the date the physician gave the orders to obtain the physician's signature and date on those orders.

Physician's Orders and Signature

All home health services require a physician's order or prescription. Services provided *before* a physician's order or prescription is obtained will not be reimbursed. The order or prescription shall be in writing or given verbally and later be reduced to writing by the nurse. All orders or prescriptions must be reviewed, signed, and dated by the prescribing physician as stated in DHS 107.02(2m), Wis. Admin. Code.

The initial POC containing the physician's orders must be reviewed, signed, and dated by the physician within 20 working days following the member's start of care. All subsequent POC must be reviewed, signed, and dated by the physician *prior* to the beginning of the new certification period.

Plan of Care Certification Period Versus Prior Authorization Period

The POC certification period and the PA period refer to two separate time periods.

The requirements for a member's POC as stated in the PA/HCA Completion Instructions apply to the POC certification period. Regardless of the PA period (which in some cases can be granted for up to one year), the POC must be completed at least every 62 days.

Requirements

As specified in and supported by DHS 101.03(124m), 105.16(10)(e), 106.02(9), and 107.02(2)(f) Wis. Admin. Code, the POC must include all of the following information:

- All pertinent diagnoses, including cognitive status.
- Type of services and equipment required.
- Frequency of visits.
- Prognosis.

- Rehabilitation potential.
- Functional capabilities and limitations, including cognitive status, dietary needs, and allergies.
- Activities permitted.
- Nutritional requirements.
- Medications and treatments.
- Any safety measures to protect against injury.
- Instructions for timely discharge or referral.
- Home health therapy services that include specific procedures and modalities to be used and the amount, frequency, and duration.
- A dated physician's signature signifying that the physician has reviewed the POC.
- Methods for delivering needed care and an indication of which, if any, professional disciplines are responsible for delivering the care.
- An identification of all other parties providing care to the member and the responsibilities of each party for that care.
- Measurable time-specific goals.
- Nursing and emergency interventions.
- Parameters for all PRN orders.
- Other items as appropriate to the member's case.
- A plan for medical emergency.
- A plan to move the member to safety in the event of a condition that threatens the member's immediate environment.

POC for ventilator-dependent members must also include the following elements:

- Ventilator settings and parameters.
- Procedures to follow in the event of accidental extubation.

Medically necessary cares as ordered by a physician are to include cares that may be claimed by professional providers *and* cares routinely provided by the family and other volunteer caregivers.

In addition to the elements required on the POC by DHS 101.03(124m), Wis. Admin. Code, agencies should include a brief clinical history and summary of the member's condition to expedite the PA request. This additional information may decrease the frequency of returned PA requests.

Start of Care Date

The start of care date is the date of the member's first billable home care visit. This date remains the same on all subsequent POC until the member is discharged from uninterrupted service.

Private Duty Nursing

Flexible Use of Weekly Hours

Flexible hours allow PDN members and their families to use authorized hours of care over an extended period of time. Hours may be used in varying amounts over the approved period of time to meet the needs of the member and his or her family. Flexible hours might be used in situations in which a primary caregiver is unable to provide as many hours of care as usual due to an acute illness. Even though flexible use of hours may be approved, the hours must still be medically necessary. Any PDN hours used over those hours approved in the flexibility period are not reimbursable.

Flexibility of hours can be requested to be used in week-long blocks of time. The most common blocks of time are periods of 1, 2, 4, 6, 8, and 9 weeks. Providers should develop a record-keeping system to keep track of the hours of care used. This will help to prevent providers from exceeding the number of hours approved in the period in which flexibility has been authorized.

One suggestion for tracking use of hours is to use the certification period in Element 4 of the PA/HCA.

Any time flexibility is requested, the date that each flexibility period starts must be clearly specified in the POC (Element 15 of the PA/HCA).

Requesting Flexible Use of Hours

To request flexibility in the use of PDN hours, members and their families should discuss with the nurse and physician the hours of medically necessary care they require and the time period in which flexibility will be used.

For example, if it is determined that up to 16 hours per day for seven days per week for a total of 112 hours per week of PDN services are required and the hours will be used flexibly over an eight-week period, the request would read as follows:

PDN RN/LPN up to 16 hours per day, seven days per week (total of 112 hours a week). Hours to be used flexibly, one to 24 hours per day, not to exceed 896 hours in an eight-week period all providers combined.

Amending Prior Authorization Requests to Include Flexible Hours

If an existing PA request has been approved without flexibility, and it is determined that the use of flexible hours would be of benefit, providers should request an amendment to the PA request and obtain new orders from the physician. The amendment must explain the reason flexibility is needed and include the specific date that use of flexible hours will start.

If a change occurs in the member's medical condition or a family medical crisis arises (e.g., the extended illness of a primary caregiver), and the coverage for these events cannot be accommodated within the authorized use of the flexible hours during the flexibility period, nurses may submit a request for additional hours through an amendment to the original PA request. The amendment must explain the reason for the additional hours in detail; however, most events can be accommodated through the use of flexibility.

Hours of Private Duty Nursing for Children

To determine the hours of PDN care for children, providers should consider the extent to which the family and/or other unpaid caregivers are capable of providing medical cares.

Approval of PDN for 24 hours per day may be considered for children in the following circumstances:

- For short-term care after institutional discharge or after in-home exacerbations with significant medical changes, allowing time to teach the family or caregivers and to stabilize the child and develop routine care techniques.
- For short-term care if a single parent or caregiver is hospitalized or if one family member or caregiver is hospitalized and the other is not capable of providing care. PDN for 24 hours per day may fill the gap until other caregivers can be taught cares or until the usual family member or caregiver can resume them.
- If the family or caregivers are not *capable* of providing *any* needed cares.

PDN may be approved for family member or caregiver work time. For example, if the family member or caregiver works outside the home, a reasonable number of PDN hours may be approved to allow for the family member or caregiver's absence from cares for work and commuting to and from work.

If overnight PDN is medically necessary, PDN may be approved for family or caregivers' sleep time. PDN may be approved for the night shift so the family or caregivers can sleep. Sleep time may be approved during the day if the family member or caregiver works during the night.

PDN may be approved for medically necessary services if the family needs time to perform family or other similar *responsibilities* of the family or caregivers such as grocery shopping, medical appointments, or picking up medical supplies.

PDN may be approved for the child's school hours when it is medically necessary for a nurse to accompany the child to school. In many cases, the child meets enrollment criteria for PDN, but is cared for at school by nurses' aides or laypersons, with a school RN available as needed.

When determining the number of PDN hours that will be approved, the following elements will be considered:

- The child's school time.
- The family or caregivers' work schedule.
- Any other pertinent information.

Indicating Flexible Use of Hours on the Plan of Care

When the flexible use of hours is requested for PDN, providers are required to specify the date that the flexibility period will begin. The PA/HCA Completion Instructions for Element 15 direct providers to include the begin date for the use of flexible hours under this element on the PA/HCA. The begin date must be a date covered under the current POC.

Prior Authorization is Required

PA is required for all PDN services before the services may be provided. When submitting a PA request for PDN, the scheduled number of hours requested should reflect the daily care needs of the member. The following should be considered when requesting PDN hours:

- Type of medically necessary skilled service needed.
- Stability and predictability of the member's clinical course.
- Availability of family/other caregivers.

The physician's orders for PDN should be written in hours per day and days per week.

Pro Re Nata Hours

PRN or "as needed," hours may be requested when there is a reason to expect a deviation in the number of scheduled hours needed due to a change in the member's needs. PRN hours must be medically necessary and the physician's orders on the POC must specify the number and purpose of the PRN hours requested.

When the provider cannot determine whether an RN or LPN will provide PRN services, the provider may request approval for both by entering both procedure codes on one line of the PA/RF. Separate the procedure codes by a slash. Include a statement that the total number of hours of care does not exceed the total number of hours on the POC.

If after using all the PRN hours granted it is found that additional hours are needed, providers may request an amendment to the PA for more PRN hours. The amendment must include documentation stating the dates all previously granted PRN hours were used and the activities performed during each PRN hour.

Shared Cases

When home health agencies are case sharing PDN services, each provider is responsible for doing the following:

- Obtaining a PA separately for the services to be performed by that provider.
- Communicating and coordinating the PA request with other case-sharing providers to assure appropriate care and reimbursement.

To reduce the chance of PA request returns and expedite the PA process, each provider is required to document specific information about the case. The PA request may be returned if information provided is incomplete and/or inconsistent.

Plan of Care

Each provider is required to indicate the following on the member's POC:

- The total number of home care hours that the member requires.
- The names of all the providers that will be sharing the case.
- The number of hours that each provider will be providing care.

Prior Authorization Request Form

Each provider is required to indicate the following in Element 21 of the PA/RF:

- The number of hours per week the provider will provide care.
- "Shared case with (name of the other provider). Total hours for all providers will not exceed total hours on POC."

Review Process

Clerical Review

The first step of the PA request review process is the clerical review. The provider, member, diagnosis, and treatment information indicated on the PA/RF, PA/HIAS1, and PA/DRF forms is reviewed during the clerical review of the PA request review process. The following are examples of information verified during the clerical review:

- Billing and/or rendering provider number is correct and corresponds with the provider's name.
- Provider's name is spelled correctly.
- Provider is Medicaid certified.
- Procedure codes with appropriate modifiers, if required, are covered services.
- Member's name is spelled correctly.
- Member's identification number is correct and corresponds with the member's name.
- Member enrollment is verified.
- All required elements are complete.
- Forms, attachments, and additional supporting clinical documentation are signed and dated.
- A current physician's prescription for the service is attached, if required.

Clerical errors and omissions are responsible for the majority of PA requests that are returned to providers for correction or additional information. Since having to return a PA request for corrections or additional information can delay approval and delivery of services to a member, providers should ensure that all clerical information is correctly and completely entered on the PA/RF, PA/DRF, or PA/HIAS1.

If clerical errors are identified, the PA request is returned to the provider for corrections before undergoing a clinical review. One way to reduce the number of clerical errors is to complete and submit PA/RFs through Web PA.

Clinical Review

Upon verifying the completeness and accuracy of clerical items, the PA request is reviewed to evaluate whether or not each service being requested meets Wisconsin Medicaid's definition of "medically necessary" as well as other criteria.

The PA attachment allows a provider to document the clinical information used to determine whether the standards of medical necessity are met for the requested service. Wisconsin Medicaid considers certain factors when determining whether to approve or deny a PA request pursuant to DHS 107.02(3)(e), Wis. Admin. Code.

It is crucial that a provider include adequate information on the PA attachment so that the ForwardHealth consultant performing the clinical review can determine that the service(s) being requested meets all the elements of Wisconsin Medicaid's definition of "medically necessary", including elements that are not strictly medical in nature. Documentation must provide the justification for the service requested specific to the member's current condition and needs. Pursuant to DHS 101.03(96m), Wis. Admin. Code, "medically necessary" is a service under ch. HFS 107 that meets certain criteria.

Determination of Medical Necessity

The definition of "medically necessary" is a legal definition identifying the standards that must be met for approval of the service. The definition imposes parameters and restrictions that are both medical and nonmedical.

The determination of medical necessity is based on the documentation submitted by the provider. For this reason, it is essential that documentation is submitted completely and accurately and that it provides the justification for the service requested, specific to the member's current condition and needs. To be approved, a PA request must meet all of the standards of medical necessity including those that are not strictly medical in nature.

To determine if a requested service is medically necessary, ForwardHealth consultants obtain direction and/or guidance from multiple resources including:

- Federal and state statutes.
- Wisconsin Administrative Code.
- PA guidelines set forth by the DHS.
- Standards of practice.
- Professional knowledge.
- Scientific literature.

Situations Requiring New Requests

Change in Billing Providers

Providers are required to submit a new PA request when there is a change in billing providers. A new PA request must be submitted with the new billing provider's name and billing provider number. The expiration date of the PA request will remain the same as the original PA request.

Typically, as no more than one PA request is allowed for the same member, the same service(s), and the same dates, the new billing provider is required to send the following to ForwardHealth's PA Unit:

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

Changes to Member Enrollment Status

Changes to a member's enrollment status may affect PA determinations. In the following cases, providers are required to obtain valid, approved PA for those services that require PA:

- A member enrolled in the BadgerCare Plus Standard Plan has a change in income level and becomes eligible for the BadgerCare Plus Benchmark Plan. The member's enrollment status changes to Benchmark Plan.
- A member enrolled in the Benchmark Plan has a change in income level or medical condition and becomes eligible for the Standard Plan or Medicaid. The member's enrollment status changes to Standard Plan or Medicaid accordingly.

Some changes in a member's enrollment status do not affect PA determinations. In the following cases, providers are not required to obtain separate PA because PA will continue to be valid:

- A member enrolled in the Standard Plan becomes eligible for Medicaid coverage. PA granted under the Standard Plan will be valid for Medicaid.
- A member switches from the Standard Plan to the Benchmark Plan and there is already a valid PA on file for the member under the Benchmark Plan.
- A member switches from the Benchmark Plan to the Standard Plan or Medicaid and there is already a valid PA on file for the member under the Standard Plan or Medicaid.

Providers are encouraged to verify enrollment before every office visit or service rendered. Verifying enrollment will help providers identify changes in member enrollment status and take appropriate actions to obtain PA for services when necessary.

The first time a member switches plans, the provider is required to submit a new PA request, including all required PA forms and attachments. If a member switches back into either of the plans and there is a valid, approved PA on file under that plan, the provider does not need to submit a new PA request.

Providers who have a provider account on the ForwardHealth Portal may use the Portal to check if a valid PA is on file for the service.

Calculating Limits for Services Requiring Prior Authorization

Any limits that pertain to services requiring PA will accumulate separately under each plan.

Examples

Examples of when a new PA request must be submitted include the following:

- A provider's billing provider changes.
- A member requests a provider change that results in a change in billing providers.
- A member's enrollment status changes and there is not a valid PA on file for the member's current plan (i.e., BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, Medicaid).

If the *rendering* provider indicated on the PA request changes but the *billing* provider remains the same, the PA request remains valid and a new PA request does *not* need to be submitted.

Services Not Performed Before Expiration Date

Generally, a new PA request with a new requested start date must be submitted to ForwardHealth if the amount or quantity of prior authorized services is not used by the expiration date of the PA request and the service is still medically necessary.

Submission Options

Fax

Faxing of all PA requests to ForwardHealth may eliminate one to three days of mail time. The following are recommendations to avoid delays when faxing PA requests:

- Follow the PA fax procedures.
- Providers should *not* fax the same PA request more than once.
- Providers should *not* fax *and* mail the same PA request. This causes delays in processing.

PA requests containing X-rays, dental molds, or photos as documentation must be mailed; they may not be faxed.

To help safeguard the confidentiality of member health care records, providers should include a fax transmittal form containing a confidentiality statement as a cover sheet to all faxed PA requests. The Prior Authorization Fax Cover Sheet includes a confidentiality statement and may be photocopied.

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

Prior Authorization Fax Procedures

Providers may fax PA requests to ForwardHealth at (608) 221-8616. PA requests sent to any fax number other than (608) 221-8616 may result in processing delays.

When faxing PA requests to ForwardHealth, providers should follow the guidelines/procedures listed below.

Fax Transmittal Cover Sheet

The completed fax transmittal cover sheet must include the following:

- Date of the fax transmission.
- Number of pages, including the cover sheet. The ForwardHealth fax clerk will contact the provider by fax or telephone if all the pages do not transmit.
- Provider contact person and telephone number. The ForwardHealth fax clerk may contact the provider with any questions about the fax transmission.
- Provider number.
- Fax telephone number to which ForwardHealth may send its adjudication decision.
- To: "ForwardHealth Prior Authorization."
- ForwardHealth's fax number ([608] 221-8616). PA requests sent to any other fax number may result in processing delays.
- ForwardHealth's telephone numbers. For specific PA questions, providers should call Provider Services. For faxing questions, providers should call (608) 221-4746, extension 80118.

Incomplete Fax Transmissions

If the pages listed on the initial cover sheet do not all transmit (i.e., pages stuck together, the fax machine has jammed, or some other error has stopped the fax transmission), or if the PA request is missing information, providers will receive the following by fax from the ForwardHealth fax clerk:

- A cover sheet explaining why the PA request is being returned.
- Part or all of the original incomplete fax that ForwardHealth received.

If a PA request is returned to the provider due to faxing problems, providers should do the following:

- Attach a completed cover sheet with the number of pages of the fax.
- Resend the entire original fax transmission and the additional information requested by the fax clerk to (608) 221-8616.

General Guidelines

When faxing information to ForwardHealth, providers should not reduce the size of the PA/RF or the PA/HIAS1 to fit on the bottom half of the cover page. This makes the PA request difficult to read and leaves no space for consultants to write a response if needed or to sign the request.

If a photocopy of the original PA request and attachments is faxed, the provider should make sure these copies are clear and legible. If the information is not clear, it will be returned to the provider.

If the provider does not indicate his or her fax number, ForwardHealth will mail the decision back to the provider.

ForwardHealth will attempt to fax a response to the PA request to a provider three times. If unsuccessful, the PA request will be mailed to the provider.

If providers are not sure if an entire fax was sent, they should call ForwardHealth's fax clerk at (608) 221-4746, extension 80118, to inquire about the status of the fax.

Prior Authorization Request Deadlines

Faxing a PA request eliminates one to three days of mail time. However, the adjudication time of the PA request has not changed. All actions regarding PA requests are made within the predetermined time frames.

Faxed PA requests received after 1:00 p.m. will be considered as received the following business day. Faxed PA requests received on a Saturday, Sunday, or holiday will be processed on the next business day.

Avoid Duplicating Prior Authorization Requests

After faxing a PA request, providers should not send the original paperwork, such as the carbon PA/RF, by mail. Mailing the original paperwork after faxing the PA request will create duplicate PA requests in the system and may result in a delay of several days to process the faxed PA request.

Refaxing a PA request before the previous PA request has been returned will also create duplicate PA requests and may result in delays.

Response Back from ForwardHealth

Once ForwardHealth reviews a PA request, ForwardHealth will fax one of three responses back to the provider:

- "Your approved, modified, or denied PA request(s) is attached."
- "Your PA request(s) requires additional information (see attached). Resubmit the entire PA request, including the attachments, with the requested additional information."
- "Your PA request(s) has missing pages and/or is illegible (see attached). Resubmit the entire PA request, including the attachments."

Resubmitting Prior Authorization Requests

When resubmitting a faxed PA request, providers are required to resubmit the faxed copy of the PA request, including attachments. This will allow the provider to obtain the earliest possible grant date for the PA request (apart from backdating for retroactive enrollment). If any attachments or additional information that was requested is received without the rest of the PA request, the information will be returned to the provider.

ForwardHealth Portal Prior Authorization

Providers can use the following PA features on the ForwardHealth Portal to do the following:

- Submit PA requests and amendments for all services that require PA.
- Receive decision notice letters and returned provider review letters.
- Correct returned PA requests and PA amendment requests.
- Search and view previously submitted PA requests.

Submitting Prior Authorization Requests and Amendment Requests

Providers can submit PA requests for all services that require PA to ForwardHealth via the secure Provider area of the Portal. To save time, providers can copy and paste information from plans of care and other medical documentation into the appropriate fields on the PA request. Except for those providers exempt from NPI requirements, NPI and related data are required on PAs submitted via the Portal.

When completing PA attachments on the Portal, providers can take advantage of an Additional Information field at the end of the PA attachment that holds up to five pages of text that may be needed.

Providers may also submit amendment requests via the Portal for PAs with a status of "Approved" or "Approved with Modifications."

PA Attachments on the Portal

Almost all PA request attachments can be completed and submitted on the Portal. When providers are completing PA requests, the Portal presents the necessary attachments needed for that PA request. For example, if a physician is completing a PA request for physician-administered drugs, the Portal will prompt a PA/JCA, and display the form for the provider to complete.

All PA request attachment forms are available on the Portal to download and print to submit by fax or mail.

Providers may also chose to submit their PA request on the Portal and mail or fax the PA attachment(s) and/or additional supporting documentation to ForwardHealth. If the PA attachment(s) are mailed or faxed, a system-generated Portal PA Cover Sheet, must be printed and sent with the attachment to ForwardHealth for processing. Providers must list the attachments on the Portal PA Cover Sheet. When ForwardHealth receives the PA attachments by mail or fax, they will be matched up with the PA/RF that was completed on the Portal.

Before submitting any PA documents, providers should save or print a copy for their records. Once the PA request is submitted, it cannot be retrieved for further editing.

As a reminder, ForwardHealth does not mail back any PA request documents submitted by the providers.

Additional Supporting Information

Providers may choose to submit additional supporting information via mail or fax. If additional supporting information is needed, providers are prompted to print a system-generated Portal PA Cover Sheet to be sent with the information to ForwardHealth for processing. Providers must list the additional supporting information on the Portal PA Cover Sheet.

For certain PA process types, providers can choose to upload electronic supporting information through the Portal. Files can be uploaded if the user selects a process type of 117 (Physician services), 124 (Dental services), or 125 (Orthodontic services). Photographs, X-rays and dental models may be uploaded through the Portal if the images are in a JPEG format or created with OrthoCad software (available free on the Web). Dental model OrthoCad files must be uploaded with an extension of ".3dm." JPEG files must be uploaded with an extension of ".jpg" or ".jpeg."

Mail

Any type of PA request may be submitted on paper. Providers may mail completed PA requests, amendments to PA requests, and requests to enddate a PA request to ForwardHealth at the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

STAT-PA

Providers can submit STAT-PA requests for a limited number of services (e.g., certain drugs, selected orthopedic shoes, lead inspections for HealthCheck). The STAT-PA system is an automated system accessed by providers by touch-tone telephone that allows them to receive an immediate decision for certain PA requests.

NPI and related data are required when using the STAT-PA system.

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

Note: A PA request cannot be approved through STAT-PA for members enrolled in the BadgerCare Plus Benchmark Plan. PA requests for members enrolled in the Benchmark Plan may be submitted online via the ForwardHealth Portal or on paper.

Reimbursement

8

Archive Date:07/01/2009

Reimbursement:Amounts

Acceptance of Payment

The amounts allowed as payment for covered services must be accepted as payment in full. Therefore, total payment for the service (i.e., any amount paid by other health insurance sources, any BadgerCare Plus or Medicaid copayment or spenddown amounts paid by the member, and any amount paid by BadgerCare Plus) may not exceed the BadgerCare Plus-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 BadgerCare Plus-allowed amount for a service (i.e., balance billing).

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

Billing Service and Clearinghouse Contracts

According to DHS 106.03(5)(c)2, Wis. Admin. Code, contracts with outside billing services or clearinghouses may not be based on commission in which compensation for the service is dependent on reimbursement from BadgerCare Plus. This means compensation must be unrelated, directly or indirectly, to the amount of reimbursement or the number of claims and is not dependent upon the actual collection of payment.

Fee Schedules

Maximum allowable fee information is available on the ForwardHealth Portal in the following forms:

- Interactive fee schedule.
- Downloadable fee schedule in TXT files.

Certain fee schedules are interactive. Interactive fee schedules provide coverage information as well as maximum allowable fees for all reimbursable procedure codes. The downloadable TXT files are free of charge and provide basic maximum allowable fee information for BadgerCare Plus by provider service area.

A provider may request a paper copy of a fee schedule by calling Provider Services.

Providers may call Provider Services in the following cases:

- Internet access is not available.
- There is uncertainty as to which fee schedule should be used.
- The appropriate fee schedule cannot be found on the Portal.
- To determine coverage or maximum allowable fee of procedure codes not appearing on a fee schedule.

Maximum Allowable Fees

Maximum allowable fees are established for most covered services. Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

Providers are reimbursed at the lesser of their billed amount and the maximum allowable fee for the procedure.

Home health aide services, home health skilled nursing services, and home health therapy services are reimbursed according to a maximum allowable fee per visit. PDN services are reimbursed based on an hourly maximum allowable fee.

Home health agencies are reimbursed only for the specific services for which they are licensed.

Collecting Payment From Members

Benchmark Plan Service Limitations

Services that exceed a service limitation established under the BadgerCare Plus Benchmark Plan are considered noncovered. Providers are required to follow certain procedures for billing members who receive these services.

Services with Visit Limitations per Enrollment Year

Under the Benchmark Plan, some services are covered until a member reaches a specified number of visits or days of service per enrollment year. These services include:

- Inpatient hospital stays for substance abuse and mental health treatment.
- Home health visits.
- Nursing home stays.
- Routine eye exams.
- Therapy visits (PT, OT, and SLP).

Note: Hospice services are subject to a lifetime limit under the Benchmark Plan.

Visits and days of service that exceed the service limitations established under the Benchmark Plan are considered noncovered. Services provided during a noncovered visit will not be reimbursed by BadgerCare Plus. Providers are encouraged to inform the member when he or she has reached a service limitation.

If a member requests a service that exceeds the limitation, the member is responsible for payment. Providers should make payment arrangements with the member in advance.

Services with Dollar Amount Limits per Enrollment Year

Under the Benchmark Plan, some services are subject to a specified dollar amount service limitation per member per enrollment year. Any products or services that exceed the dollar amount limit are considered noncovered.

If BadgerCare Plus reimburses any portion of the charges for the service, providers are required to accept the BadgerCare Plus allowed reimbursement, which is the lesser of the provider's usual and customary charges or the maximum allowable fee, as payment in full. If BadgerCare Plus pays a portion of the claim and the claim exceeds the member's dollar amount service limitation, providers can balance bill the member for the difference between the allowed reimbursement and the dollar amount actually paid by BadgerCare Plus.

For example, the Benchmark Plan reimburses up to $2,500.00 for DME per member per enrollment year. Suppose a member has expended $2,200.00 of her DME coverage and requires a new DME item. The BadgerCare Plus-allowed reimbursement for this DME item is $500.00. BadgerCare Plus will reimburse only $300.00 before the member has exhausted his or her coverage. The member is responsible for the additional $200.00. The provider must still accept $500.00 as payment in full because BadgerCare Plus reimbursed a portion of the charges. The provider must not bill the member for more than $200.00.

If a member has already met or exceeded his or her dollar limit, BadgerCare Plus will not reimburse providers for services provided to that member. Providers can bill members up to their usual and customary charges for noncovered services.

Conditions That Must Be Met

A member may request a noncovered service, a covered service for which PA was denied (or modified), or a service that is not covered under the member's limited benefit category. The charge for the service may be collected from the member if the following conditions are met *prior* to the delivery of that service:

- The member accepts responsibility for payment.
- The provider and member make payment arrangements for the service.

Providers are strongly encouraged to obtain a *written* statement in advance documenting that the member has accepted responsibility for the payment of the service.

Furthermore, the service must be separate or distinct from a related, covered service. For example, a vision provider may provide a member with eyeglasses but then, upon the member's request, provide and charge the member for anti-glare coating, which is a noncovered service. Charging the member is permissible in this situation because the anti-glare coating is a separate service and can be added to the lenses at a later time.

Cost Sharing

According to federal regulations, providers cannot hold a member responsible for any commercial or Medicare cost-sharing amount such as coinsurance, copayment, or deductible. Therefore, a provider may not collect payment from a member, or authorized person acting on behalf of the member, for copayments required by other health insurance sources. Instead, the provider should collect *only* the copayment amount from the member.

Situations When Member Payment Is Allowed

Providers may not collect payment from a member, or authorized person acting on behalf of the member, *except* for the following:

- Required member copayments for certain services.
- Commercial insurance payments made to the member.
- Spenddown.
- Charges for a private room in a nursing home or hospital.
- Noncovered services if certain conditions are met.
- Covered services for which PA was denied (or an originally requested service for which a PA request was modified) if certain conditions are met. These services are treated as noncovered services.
- Services provided to a member in a limited benefit category when the services are not covered under the limited benefit and if certain conditions are met.

If a provider inappropriately collects payment from a member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid certification.

Copayment

Amounts

The copayment amount for home health services under the BadgerCare Plus Benchmark Plan is $15.00 per visit. A visit is defined as all home health services provided on the same DOS by the same rendering provider. A single $15.00 copayment applies regardless of the number or type of procedures administered during the visit.

Exemptions

Certain BadgerCare Plus Benchmark Plan members are exempt from copayment requirements, including the following:

- Members under 18 years old who are members of a federally recognized tribe.
- Pregnant women.

The following services do not require copayment under the Benchmark Plan:

- Family planning services.
- Preventive services, including HealthCheck screenings.

Limitations

Providers should verify that they are collecting the correct copayment for services as some services have monthly or annual copayment limits. Providers may not collect member copayments in amounts that exceed copayment limits.

Prohibited

Home health service providers are prohibited from collecting copayment from BadgerCare Plus Standard Plan and Medicaid members for home health services, PDN services provided to members under age 18, and personal care services.

Refund/Collection

If a provider collects a copayment before providing a service and BadgerCare Plus does not reimburse the provider for any part of the service, the provider is required to return or credit the entire copayment amount to the member.

If BadgerCare Plus deducts less copayment than the member paid, the provider is required to return or credit the remainder to the member. If BadgerCare Plus deducts more copayment than the member paid, the provider may collect the remaining amount from the member.

Requirements

Federal law permits states to charge members a copayment for certain covered services. Providers are required to request copayments from members. Providers may not deny services to a Wisconsin Medicaid or BadgerCare Plus Standard Plan member who fails to make a copayment; however, providers may deny services to a BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, or aBadgeCare Plus Core Plan member who fails to make a copayment.

Chapter 49.45(18), Wis. Stats., requires providers to make a reasonable attempt to collect copayment from the member unless the provider determines that the cost of collecting the copayment exceeds the amount to be collected.

Payer of Last Resort

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:

- B-3.
- Crime Victim Compensation Fund.
- GA.
- HCBS waiver programs.
- IDEA.
- Indian Health Service.
- Maternal and Child Health Services.
- WCDP.
  - 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.

Other Health Insurance Sources

BadgerCare Plus reimburses only that portion of the allowed cost remaining after a member's other health insurance sources have been exhausted. Other health insurance sources include the following:

- Commercial fee-for-service plans.
- Commercial managed care plans.
- Medicare supplements (e.g., Medigap).
- Medicare.
- Medicare Advantage.
- TriCare.
- CHAMPVA.
- Other governmental benefits.

Payer of Last Resort

Except for a few instances, Wisconsin Medicaid or BadgerCare Plus are the payer of last resort for any covered services. Therefore, the provider is 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.

Primary and Secondary Payers

The terms "primary payer" and "secondary payer" indicate the relative order in which insurance sources are responsible for paying claims.

In general, commercial health insurance is primary to Medicare, and Medicare is primary to Wisconsin Medicaid and BadgerCare Plus. Therefore, Wisconsin Medicaid and BadgerCare Plus are secondary to Medicare, and Medicare is secondary to commercial health insurance.

Reimbursement Not Available

Reimbursement Not Available

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

Home health agencies may not receive Medicaid reimbursement for the services stated in DHS 107.11(5), Wis. Admin. Code. These services include, but are not limited to the following:

- Services that are not medically necessary as defined in DHS 101.03(96m), Wis. Admin. Code, including, but not limited to, services that are:
  - Duplicative with respect to other services provided.
  - Provided solely for the convenience of the member, member's family, or a provider.
  - Not cost-effective compared to an alternative medically necessary service that is reasonably accessible to the member.
- Any services that do not make effective and appropriate use of available services.
- More than one initial visit per day by a home health skilled nurse, home health aide, physical or occupational therapist, or speech and language pathologist.
- Services requiring PA that are provided without PA.
- Supervision of the member when supervision is the only service provided at the time. This includes supervision provided to give the primary caregiver a respite from care.
- Hospice care provided under DHS 107.31, Wis. Admin. Code.
- Mental health and substance abuse services provided under DHS 107.13(2), (3), (3m), (4), and (6), Wis. Admin. Code.
- Medication administration by a PCW or a home health aide that has not been delegated by an RN according to the relevant provisions of DHS 133, Wis. Admin. Code.
- Home health skilled nursing services contracted by a home health agency unless the requirements of DHS 133.19, Wis. Admin. Code, are met and approved.
- Home health services to a member who is eligible for covered services under the Medicare program or any other insurance held by the member.
- Parenting.
- Services to other members of the member's household.
- Services provided to a member by legally responsible relatives in accordance with ch. 49.90, Wis. Stats.
- Skilled nursing visits solely for the purpose of ensuring that a member who has a demonstrated history of noncompliance over 30 days complies with the medications program, as required by DHS 107.11(5)(L)1, Wis. Admin. Code.
- A skilled nursing visit to ensure compliance with the medication regimen of an adult member who has a demonstrated history of non-compliance over 30 days.
- Medication administration to a minor child unless the parents are unable to administer the medication.
- A skilled nursing visit to administer medication to an adult member who is capable, but chooses not to, self-administer the medication. A member is considered "capable" if the member has no physicial or mental condition that would prevent the member from self-administering the medication.
- Activities for the general welfare of a member, e.g., general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation do not constitute skilled therapy.
- Therapy that requires only the use of equipment without the skills of a therapy provider is not covered.
- Group therapy.

Reimbursement Not Available Through a Factor

BadgerCare Plus will not reimburse providers through a factor, either directly or by virtue of a power of attorney given to the factor by the provider. A factor is an organization (e.g., a collection agency) or person who advances money to a provider for the purchase or transferal of the provider's accounts receivable. The term "factor" does not include business representatives, such as billing services, clearinghouses, or accounting firms, which render statements and receive payments in the name of the provider.

Services Not Separately Reimbursable

If reimbursement for a service is included in the reimbursement for the primary procedure or service, it is not separately reimbursable. For example, routine venipuncture is not separately reimbursable, but it is included in the reimbursement for the laboratory procedure or the laboratory test preparation and handling fee. Also, DME delivery charges are included in the reimbursement for DME items.

Resources

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Archive Date:07/01/2009

Resources:Contact Information

Member Services

Providers should refer ForwardHealth members with questions to Member Services. The telephone number for Member Services is for member use only.

Professional Relations Representatives

Professional Relations representatives, also known as field representatives, answer 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.

Providers are encouraged to initially obtain information through the ForwardHealth 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.
- Online PA requests.
- PES software.
- Education and information for newly certified providers and staff.
- Participation in professional association meetings.
- Previous attempts to resolve claims processing problems through normal channels (e.g., telephone or written correspondence) have been unsuccessful. Providers are reminded that all claims and adjustments need to be submitted within 365 days from the claims submission deadline.
- They are referred by a Provider Services telephone correspondent.
- They need assistance with a complex issue requiring extensive explanation.

Field representatives primarily 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.

Information to Have Ready

Providers or their representatives should have the following information ready when they call:

- Name or alternate contact.
- County and city where services are provided.
- Name of facility or provider whom they are representing.
- NPI or provider number.
- Telephone 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:

- Member's name.
- Member identification number.
- Claim number.
- DOS.

Professional Relations Representatives Listed by Region

Professional Relations representatives are available to assist providers in all areas of Wisconsin.

Region/Name	Counties	
South Central	Columbia	Green Lake

Wisconsin Jude Benish, (608) 836-9428	Dane Dodge	Jefferson Marquette	
Northeast Wisconsin Lori Hock, (920) 634-6450	Brown Calumet Door Florence Forest Kewaunee Langlade Lincoln	Manitowoc Marathon Marinette Menominee Oconto Oneida Outagamie	Portage Shawano Sheboygan Vilas Waupaca Wausahra Winnebago
Southwest Wisconsin Cindy Drury, (608) 929-4030	Adams Crawford Fond du Lac Grant Green Iowa Juneau	Kenosha La Crosse LaFayette Monroe Ozaukee Racine Richland	Rock Sauk Vernon Walworth Washington Waukesha
Milwaukee County Teresa Miller or Maria Schwartz, (262) 695-1915	Milwaukee		
Northwest Wisconsin Denise Kruswicki, (715) 694-2114	Ashland Barron Bayfield Buffalo Burnett Chippewa Clark Douglas	Dunn Eau Claire Iron Jackson Pepin Pierce Polk Price	Rusk St. Croix Sawyer Taylor Trempealeau Washburn Wood
North Central Wisconsin Joan Buntin, (715) 675-3190	Assistance with Web PA and PES software representative support for Northwest, North Central, and Northeast Wisconsin.		
Southeast Wisconsin Vicky Murphy, (608) 756-1422	Assistance with Web PA and PES software representative support for Southwest, South Central, and Southeast Wisconsin, and Milwaukee County.		

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, and WWWP 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 submissions.
- Certification.
- COB (e.g., verifying a member's other health insurance coverage).
- Assistance with completing forms.

- Assistance with remittance information and claim denials.
- Policy clarification.
- PA 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 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 member identification number.
- Claim number.
- PA number.
- DOS.
- Amount billed.
- RA.
- Procedure code of the service in question.
- Reference to any provider publications that address the inquiry.

Call Center Correspondent Team

The ForwardHealth call center correspondents are organized to respond to telephone calls from providers. Correspondents offer assistance and answer inquiries specific to the program (i.e., Medicaid, WCDP, or WWWP) or to the service area (i.e., pharmacy services, hospital services) in which they are designated.

Call Center Menu Options and Inquiries

Providers contacting Provider Services are prompted to select from the following menu options:

- WCDP and WWWP (for inquiries from all providers regarding WCDP or WWWP).
- Dental (for all inquiries regarding dental services).
- Medicaid or SeniorCare Pharmacy (for pharmacy providers) or STAT-PA for STAT-PA inquiries, including inquiries from pharmacies, DME providers for orthopedic shoes, and HealthCheck providers for environmental lead inspections.
- Medicaid and BadgerCare Plus institutional services (for inquiries from providers who provide hospital, nursing home, home health, personal care, ESRD, and hospice services or NIP).
- Medicaid and BadgerCare Plus professional services (for inquiries from all other providers not mentioned in the previous menu prompts).

Walk-in Appointments

Walk-in appointments offer face-to-face assistance for providers at the Provider Services office. Providers are encouraged to contact the Provider Services Call Center to schedule a walk-in appointment.

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 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
6406 Bridge Rd
Madison WI 53784-0005

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.

Provider Suggestions

The DHCAA is interested in improving its program for providers and members. Providers who would like to suggest a revision of any policy or procedure stated in provider publications or who wish to suggest new policies are encouraged to submit recommendations on the Provider Suggestion form.

Resources Reference Guide

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

Electronic Data Interchange

Companion Documents

Purpose of Companion Documents

ForwardHealth companion documents provide trading partners with useful technical information on ForwardHealth's standards for nationally recognized electronic transactions.

The information in companion documents applies to BadgerCare Plus, Medicaid, SeniorCare, WCDP, and WWWP. Companion documents are intended for information technology and systems staff who code billing systems or software.

The companion documents complement the federal HIPAA Implementation Guides and highlight information that trading partners need to successfully exchange electronic transactions with ForwardHealth, including general topics such as the following:

- Methods of exchanging electronic information (e.g., exchange interfaces, transaction administration, and data preparation).
- Instructions for constructing the technical component of submitting or receiving electronic transactions (e.g., claims, RA, and enrollment inquiries).

Companion documents do *not* include program requirements, but help those who create the electronic formats for electronic data exchange.

Companion documents cover the following specific subjects:

- Getting started (e.g., identification information, testing, and exchange preparation).
- Transaction administration (e.g., tracking claims submissions, contacting the EDI Helpdesk).
- Transaction formats.

Revisions to Companion Documents

Companion documents may be updated as a result of changes to federal requirements. When this occurs, ForwardHealth will do the following:

- Post the revised companion document on the ForwardHealth Portal.
- Post a message on the banner page of the RA.
- Send an e-mail to trading partners.

Trading partners are encouraged to periodically check for the revised companion documents on the Portal. If trading partners do not follow the revisions identified in the companion document, transactions may not process successfully (e.g., claims may deny or process incorrectly).

A revision log located at the front of the revised companion document lists the changes that have been made. The date on the companion document reflects the last date the companion document was revised. In addition, the version number located in the footer of the first page is changed with each revision.

Data Exchange Methods

The following data exchange methods are supported by the EDI Department:

- Remote access server dial-up, using a personal computer with a modem, browser, and encryption software.
- Secure Web, using an Internet Service Provider and a personal computer with a modem, browser, and encryption software.
- Real-time, by which trading partners exchange the NCPDP 5.1 (pharmacies only), 270/271, or 276/277 transactions via an approved clearinghouse.

The EDI Department supports the exchange of the transactions for BadgerCare Plus, Medicaid, SeniorCare, WCDP, and WWWP.

Electronic Data Interchange Helpdesk

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

Providers with policy questions should call Provider Services.

Electronic Transactions

Trading partners may submit claims and adjustment requests, inquire about member enrollment, claim status, and ForwardHealth payment advice by exchanging electronic transactions.

Through the EDI Department, trading partners may exchange the following electronic transactions:

- 270/271. The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.
- 276/277. The 276 is the electronic transaction for checking claim status. The 277 is received in response.
- 835. The electronic transaction for receiving remittance information.
- 837. The electronic transaction for submitting claims and adjustment requests.
- 997. The electronic transaction for reporting whether a transaction is accepted or rejected.
- TA1 Interchange Acknowledgment. The electronic transaction for reporting a transaction that is rejected for interchange level errors.
- NCPDP 5.1 Telecommunication Standard for Retail Pharmacy Claims. The real-time POS electronic transaction for submitting pharmacy claims.

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. The PES software allows providers to submit 837 transactions and download the 997 and the 835 transactions. To obtain PES software, providers may download it from the ForwardHealth Portal or may request it from the EDI Helpdesk.

Trading Partner Profile

A TPP must be completed and signed for each billing provider number that will be used to exchange electronic transactions.

In addition, billing providers who do not use a third party to exchange electronic transactions, billing services, and clearinghouses are required to complete a TPP.

To determine whether a TPP is required, providers should refer to the following:

- Billing providers who do not use a third party to exchange electronic transactions, including providers who use the PES software, are required to complete the TPP.
- Billing providers who use a third party (billing services and clearinghouses) to exchange electronic transactions are required to submit a TPP.
- Billing services and clearinghouses, including those that use PES software, that are authorized by providers to exchange electronic transactions on a provider's behalf, are required to submit a TPP.

Providers who change billing services and clearinghouses or become a trading partner should keep their information updated by contacting the EDI Helpdesk.

Trading Partners

ForwardHealth exchanges nationally recognized electronic transactions with trading partners. A "trading partner" is defined as a covered entity that exchanges electronic health care transactions. The following covered entities are considered trading partners:

- Providers who exchange electronic transactions directly with ForwardHealth.

- Billing services and clearinghouses that exchange electronic transactions directly with ForwardHealth on behalf of a billing provider.

Enrollment Verification

270/271 Transactions

The 270/271 transactions allow for batch enrollment verification, including information for the current benefit month and previous 365 days, through a secure Internet connection. The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.

For those providers who are federally required to have an NPI, an NPI is required on the 270/271 transactions. The NPI indicated on the 270 is verified to ensure it is associated with a valid certification on file with ForwardHealth. The 271 response will report the NPI that was indicated on the 270.

For those providers exempt from NPI, a provider ID is required on the 270/271 transactions. The provider ID indicated on the 270 is verified to ensure it is associated with a valid certification on file with ForwardHealth. The 271 response will report the provider ID that was indicated on the 270.

An Overview

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

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

Commercial Enrollment Verification Vendors

ForwardHealth has agreements with several commercial enrollment verification vendors to offer enrollment verification technology to ForwardHealth providers. Commercial enrollment verification vendors have up-to-date access to the ForwardHealth enrollment files to ensure that providers have access to the most current enrollment information. Providers may access Wisconsin's EVS to verify member enrollment through one or more of the following methods available from commercial enrollment verification vendors:

- Magnetic stripe card readers.
- Personal computer software.
- Internet.

Vendors sell magnetic stripe card readers, personal computer software, Internet access, and other services. They also provide ongoing maintenance, operations, and upgrades of their systems. Providers are responsible for the costs of using these enrollment verification methods.

Note: Providers are *not* required to purchase services from a commercial enrollment verification vendor. For more information on other ways to verify member enrollment or for questions about ForwardHealth identification cards, contact Provider Services.

Refer to the ForwardHealth Portal for a list of commercial enrollment verification vendors that provide these services.

The real-time enrollment verification methods allow providers to print a paper copy of the member's enrollment information, including a transaction number, for their records. Providers should retain this number or the printout as proof that an inquiry was made.

Magnetic Stripe Card Readers

The magnetic stripe card readers resemble credit card readers. Some ForwardHealth identification cards have a magnetic stripe and signature panel on the back, and a unique, 16-digit card number on the front. The 16-digit card number is valid only for use with a magnetic card reader.

Providers receive current member enrollment information after passing the ForwardHealth card through the reader or entering the member identification number or card number into a keypad and entering the DOS about which they are inquiring.

Personal Computer Software

Personal computer software can be integrated into a provider's current computer system by using a modem and can access the same information as the magnetic stripe card readers.

Internet Access

Some enrollment verification vendors provide real-time access to enrollment from the EVS through the Internet.

Copayment Information

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

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

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

Enrollment Verification System

Member enrollment issues are the primary reason claims are denied. To reduce claim denials, 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. Providers may want to verify the member's enrollment a second time before submitting a claim to find out whether the member's enrollment information has changed since the appointment.

Providers can access Wisconsin's EVS to receive the most current enrollment information through the following methods:

- ForwardHealth Portal.
- WiCall, Wisconsin's AVR system.
- Commercial enrollment verification vendors.
- 270/271 transactions.
- Provider Services.

Providers cannot charge a member, or authorized person acting on behalf of the member, for verifying his or her enrollment.

The EVS does not indicate other government programs that are secondary to Wisconsin Medicaid.

Enrollment Verification on the Portal

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

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

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

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

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

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

Entering Dates of Service

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

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

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

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

Member Forgets ForwardHealth Identification Card

Even if a member does not present a ForwardHealth identification card, a provider can use Wisconsin's EVS to verify enrollment, otherwise, the provider may choose not to provide the service(s) until a member brings in a ForwardHealth card.

A provider may use a combination of the member's name, date of birth, ForwardHealth identification number, or SSN with a "0" at the end to access enrollment information through the EVS.

A provider may call Provider Services with the member's full name and date of birth to obtain the member's enrollment information if the member's identification number or SSN is not known.

Member Identification Card Does Not Guarantee Enrollment

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

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

Responses Are Based on Financial Payer

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

There are three financial payers under ForwardHealth:

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

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

Forms

An Overview

ForwardHealth requires providers to use a variety of forms for PA, claims processing, and documenting special circumstances.

Fillable Forms

Most forms may be obtained from the Forms page of the ForwardHealth Portal.

Forms on the Portal are available as fillable PDF files, which can be viewed with Adobe Reader® computer software. Providers may also complete and print fillable PDF files using Adobe Reader®.

To complete a fillable PDF, follow these steps:

- Select a specific form.
- Save the form to the computer.
- Use the "Tab" key to move from field to field.

Note: The Portal provides instructions on how to obtain Adobe Reader® at no charge from the Adobe® Web site. Adobe Reader® only allows providers to view and print completed PDFs. It does not allow users to save completed fillable PDFs to their computer; however, if Adobe Acrobat® is purchased, providers may save completed PDFs to their computer. Refer to the Adobe® Web site for more information about fillable PDFs.

Selected forms are also available in fillable Microsoft® Word format on the Portal. The fillable Microsoft® Word format allows providers to complete and print the form using Microsoft® Word. To complete a fillable Microsoft® Word form, follow these steps:

- Select a specific form.
- Save the form to the computer.
- Use the "Tab" key to move from field to field.

*Note:*Providers may save fillable Microsoft® Word documents to their computer by choosing "Save As" from the "File" menu, creating a file name, and selecting "Save" on their desktop.

Telephone or Mail Requests

Providers who do not have Internet access or who need forms that are not available on the ForwardHealth Portal may obtain them by doing either of the following:

- Requesting a paper copy of the form by calling Provider Services. Questions about forms may also be directed to Provider Services.
- Submitting a written request and mailing it to ForwardHealth. Include a return address, the name of the form, and the form number and send the request to the following address:

  ForwardHealth
  Form Reorder
  6406 Bridge Rd
  Madison WI 53784-0003

Portal

Claims and Adjustments Using the ForwardHealth Portal

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

Providers can submit an individual claim through DDE through the secure Portal.

Cost Share Reports for Long-Term Managed Care Organizations

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

Creating a Provider Account

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

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

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

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

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

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

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

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

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

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

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

Electronic Communications

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

Enrollment Verification

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

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

Using the Portal to check enrollment may be more effective than calling WiCall or the EVS (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.

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.
- Partners.

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

ForwardHealth Portal Helpdesk

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

Inquiries to ForwardHealth Via the Portal

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

Internet Connection Speed

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

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

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

Logging in to the Provider Area of the Portal

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

Managed Care Organization Portal

Information and Functions Through the Portal

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

The following information is available through the Portal:

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

Managed Care Organization Portal Reports

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

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

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

Capitation Payment Listing Report

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

Initial Enrollment Roster Report

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

Final Enrollment Roster Report

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

Other Reports

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

Members ForwardHealth Portal

Members can access ForwardHealth information by going to the ForwardHealth Portal. Members 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.

Obtaining a Personal Identification Number

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

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

Providers may request a PIN by following these steps:

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

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

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

Online Handbook

The Online Handbook allows providers access to all policy and billing information for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and WCDP in one centralized place. A secure ForwardHealth Portal account is not required to use the Online Handbook as it is available to all Portal visitors.

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

The Online Handbook, which is available through the public area of the Portal, is designed to sort information based on user-entered criteria, such as program and provider type. It is organized into section and chapters. Sections within each handbook may include the following:

- Certification.
- Claims.
- Coordination of Benefits.
- Managed Care.
- Member Information.
- Prior Authorization.
- Reimbursement.
- Resources.

Each section consists of separate chapters (e.g, claims submission, procedure codes), which contain further detailed information.

Advanced Search Function

The Online Handbook has an advanced search function, which allows providers to search for a specific word or phrase within a user type, program, service area, or throughout the entire Online Handbook.

Providers can access the advanced search function by following these steps:

1. Go to the Portal.
2. Click the "Online Handbooks" link in the upper left "Providers" box.
3. Complete the two drop-down selections at the right to narrow the search by program and service area, if applicable. This is not needed if providers wish to search the entire Online Handbook.
4. Click "Advanced Search" to open the advanced search options.
5. Enter the word or phrase you would like to search.
6. Select "Search within the options selected above" or "Search all handbooks, programs and service areas."
7. Click the "Search" button.

Archive Area

The Archive Information area of the Online Handbook allows providers to view old *Updates* and previous versions of the Online Handbook.

Providers can access the archive information area by following these steps:

1. Go to the Portal.
2. Click the "Online Handbooks" link in the upper left "Providers" box.
3. Select a program and service area. (Both of these fields are required.)
4. Click on the "Updates and Handbooks" link.

Other Business Enhancements on the Portal

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

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

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.
- 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. 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 are maintained at all times. The HIPAA Privacy Rule provides guidelines governing the disclosure of PHI. The HIPAA Security Rule delineates the security measures to be implemented for the protection of electronic PHI. If Portal administrators have any questions concerning the protection of PHI, visit the Portal for additional information.

Portal administrators have access to all secure functions for their Portal account.

Establish an Administrator Account

All Portal accounts require an administrator account. The administrator is a selected individual who has overall responsibility for management of the account. Therefore, he or she has complete access to all functions within the specific secure area of his or her Portal and are permitted to add, remove, and manage other individual roles.

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 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.

Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their Portal account. Clerks may be assigned one or many roles (i.e., claims, PA, enrollment verification). Clerks do not have the ability to establish, modify, or remove other accounts.

Once a clerk account is set up, the clerk account does not have to be established again for a separate Portal account. Clerks can easily be assigned a role for different Portal accounts (i.e., different ForwardHealth certifications). To perform work under a different Portal account for which they have been granted authorization, a clerk can use the "switch org" function and toggle between the Portal accounts to which they have access. Clerks may be granted different authorization in each Portal account (i.e., they may do enrollment verification for one Portal account, and HealthCheck inquires for another).

Submitting Prior Authorization and Amendment Requests Via the Portal

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

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

Public Area of the Provider Portal

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

Maximum Allowable Fee Schedules

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

Online Handbook

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

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

Training

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

Contacting Provider Services

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

Online Certification

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

Other Business Enhancements Available on the Portal

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

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

Secure Area of the Provider Portal

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

Claims and Adjustments Using the Portal

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

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

Submitting Prior Authorization and Amendment Requests Via the Portal

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

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

Electronic Communications

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

Enrollment Verification

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

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

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

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

System and Browser Requirements

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

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

Trading Partner Portal

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

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

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

Updates

Full-Text Publications Available

Providers may request full-text versions of *ForwardHealth Updates* to be mailed to them by calling Provider Services.

General Information

ForwardHealth Updates are the first source of provider information. *Updates* announce the latest information on policy and coverage changes, PA submission requirements, claims submission requirements, and training announcements.

All providers receive the *ForwardHealth Update Summary* on a monthly basis. The *Update Summary* contains an overview of *Updates* published that month.

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

Providers may obtain copies of *Updates* listed in the *Update Summary* from the ForwardHealth Portal. A Web address that directly links providers to a list of each month's *Updates* is listed in the *Update Summary*. Providers may then print specific articles to keep on paper as well as navigate to other Medicaid information available on the Portal.

Providers without Internet access may call Provider Services to request a paper copy of an *Update*. To expedite the call, correspondents will ask providers for the *Update* number. Providers should allow seven to 10 business days for delivery.

Multiple Ways to Access ForwardHealth Publications

Providers may choose to receive notification on paper via U.S. mail or through a new e-mail subscription service. Providers who have established a ForwardHealth Portal account will automatically receive notification of *ForwardHealth Updates* and the monthly *ForwardHealth Update Summary* in their Portal message box. Providers will receive notification via their Portal accounts or e-mail subscription much sooner than on paper. Certain providers may choose not to receive *Updates* and the monthly *Update Summary*.

ForwardHealth Portal Account

Providers who establish a Portal account will not receive the *Update Summary* on paper through the U.S. mail. Providers are still bound to the program's rules, policies, and regulations even if they do not receive the *Update Summary* through the mail.

Mail

ForwardHealth will mail the monthly *Update Summary* to providers who do not have a Portal account.

E-mail Subscription Service

Providers and other interested parties may sign up on the Portal to receive e-mail notifications of new provider publications. Users are able to select, by program (Wisconsin Medicaid, BadgerCare Plus, or WCDP) and provider type (e.g., physician, hospital, DME vendor), and which publication notifications they would like to receive. Any number of staff or other interested parties from an organization may sign up for an e-mail subscription. Providers who sign up for an e-mail subscription will continue to receive paper copies of the monthly *Update Summary*.

Users may sign up for an e-mail subscription by following these steps:

1. Go to the Portal.
2. Click on the "Providers" link or button.
3. Click the "Subscribe to Provider Notifications" link from the Quick Links box on the right side of the screen.

4. Register by supplying e-mail address.

Users may register for additional electronic subscriptions by adding service areas listed under "Available Subscriptions" on the right side of the subscriptions page.

WiCall

Enrollment Inquiries

WiCall is an AVR system that allows providers with touch-tone telephones direct access to enrollment information. A WiCall Quick Reference Guide for Enrollment Inquiries is available.

Information from WiCall will be returned in the following order if applicable to the member's current enrollment:

- Transaction number: A number will be given as a transaction confirmation that providers should keep for their records.
- Benefit enrollment: All benefit plans the member is enrolled in on the DOS or within the DOS range selected for the financial payer.
- County Code: The member's county code will be provided if available. The county code is a two-digit code between 01 and 72 that represents the county in which member resides. If the enrollment response reflects that the member resides in a designated HPSA on the DOS or within the DOS range selected, HPSA information will be given.
- MCO: All information about state-contracted MCO enrollment, including MCO names and telephone numbers (that exists on the DOS or within the DOS range selected), will be listed. This information is applicable to Medicaid and BadgerCare Plus members only.
- Hospice: If the member is enrolled in the hospice benefit on the DOS or within the DOS range that the provider selected, the hospice information will be given. This information is applicable to Medicaid and BadgerCare Plus members only.
- Lock-in: Information about member lock-in that exists on the DOS or within the DOS range selected will be provided. This information is applicable to Medicaid, BadgerCare Plus, and SeniorCare members only.
- Medicare: All information about Medicare coverage, including type of coverage and Medicare number, if available, that exists on the DOS or within the DOS range selected will be listed.
- Other Commercial Insurance Coverage: All information about commercial coverage, including carrier names and telephone numbers, if available, that exists on the DOS or within the DOS range selected will be listed.
- Transaction Completed: After the member's enrollment information has been given using the financial payer that was selected, providers will be given the following options:
  - To hear the information again.
  - To request enrollment information for the same member using a different financial payer.
  - To hear another member's enrollment information using the same financial payer.
  - To hear another member's enrollment information using a different financial payer.
  - To return to the main menu.

WiCall is available 24 hours a day, seven days a week. If for some reason the system is unavailable, providers may call Provider Services.

Transaction Number

The AVR system issues a transaction number every time a provider verifies enrollment, even when an individual is *not* enrolled in BadgerCare Plus or Wisconsin Medicaid. The provider should retain this transaction number. It is proof that an inquiry was made about the member's enrollment. If a provider thinks a claim was denied in error, the provider can reference the transaction number to ForwardHealth to confirm the enrollment response that was actually given.

Entering Letters into WiCall

For some WiCall inquries, health care providers are required to enter their taxonomy code with their NPI. Because taxonomy codes are a combination of numbers and letters, telephone key pad combinations, shown in the table below, allow providers to successfully enter taxonomy code letters for WiCall functions (e.g., press *21 to enter an "A," press *72 to enter an "R").

Letter	Key Combination	Letter	Key Combination
A	*21	N	*62
B	*22	O	*63
C	*23	P	*71
D	*31	Q	*11
E	*32	R	*72

F	*33	S	*73
G	*41	T	*81
H	*42	U	*82
I	*43	V	*83
J	*51	W	*91
K	*52	X	*92
L	*53	Y	*93
M	*61	Z	*12

Additionally, providers may select option 9 and press "#" for an automated voice explanation of how to enter letters in WiCall.

Information Available Via WiCall

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

- Claim status.
- Enrollment verification.
- PA status.
- Provider CheckWrite information.

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

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

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

Claim Status

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

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

Enrollment Verification

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

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

Prior Authorization Status

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

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.

Quick Reference Guide

The WiCall AVR Quick Reference Guide displays the information available for WiCall inquiries.