Claims

1

Archive Date:01/02/2013

Claims:Adjustment Requests

Topic #814

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 (Remittance Advice) 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.

Topic #815

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.

Topic #512

Electronic

837 Transaction

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

Provider Electronic Solutions Software

The DHCAA (Division of Health Care Access and Accountability) offers electronic billing software at no cost to providers. The PES (Provider Electronic Solutions) software allows providers to submit electronic adjustment requests using an 837 transaction. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Portal Claim Adjustments

Providers can submit claim adjustments via the Portal. Providers may use the search function to find the specific claim to adjust. Once found, the provider can alter the claim to reflect the desired change and resubmit it to ForwardHealth. Any claim ForwardHealth has paid can be adjusted and resubmitted on the Portal, regardless of how the claim was originally submitted.

Topic #513

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 (Electronic Data Interchange) Helpdesk for assistance with electronic adjustment requests.

Topic #515

Paper

Paper adjustment requests must be submitted using the Adjustment/Reconsideration Request (F-13046 (07/12)) form.

Topic #816

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.

Topic #514

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.

Topic #4938

Submitting Adjustments for Inpatient Hospital and Nursing Home Crossover Claims

Revenue code/charges are not combined under revenue code 0018 or 0160 on institutional crossover claims. Revenue codes 0018 and 0160 were used by ForwardHealth in the previous system in place of the revenue codes billed to Medicare because the number of details on the claim could exceed the maximum allowed by Wisconsin Medicaid. This is not necessary since the implementation of ForwardHealth interChange as the system is now able process claims with the maximum number of allowed details (i.e., 50 details on a paper claim, 999 details on an 837 (837 Health Care Claim) electronic claim).

ForwardHealth's paper RA (Remittance Advice) and the 835 (835 Health Care Claim Payment/Advice) will show the revenue code/charge for each detail as processed by Medicare. Therefore, providers who want to adjust a crossover claim that processed under revenue codes 0018 or 0160 must submit an Adjustment/Reconsideration Request (F-13046 (07/12)) form, along with the Medicare EOMB (Explanation of Medicare Benefits) showing all revenue codes and amounts from the original Medicare claim.

Topic #4857

Submitting Paper Attachments with Electronic Claim Adjustments

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

Good Faith Claims

Topic #518

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 (Express Enrollment) 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 (Enrollment Verification System) 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 (Explanation of Benefits) code, providers should contact Provider Services for assistance.

Overpayments

Topic #532

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-enrolled on the DOS (date of service).
- 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 guide for the appropriate 837 (837 Health Care Claim) transaction when submitting adjustment requests.

Paper Adjustment Requests

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

- Submit an Adjustment/Reconsideration Request (F-13046 (07/12)) 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.

Topic #531

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 (Remittance Advice).

Topic #3449

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 Wisconsin Medicaid 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.
- 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.

Topic #8417

Voiding Claims

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

Responses

Topic #540

An Overview of the Remittance Advice

The RA (Remittance Advice) provides important information about the processing of claims and adjustment requests as well as additional financial transactions such as refunds or recoupment amounts withheld. ForwardHealth provides electronic RAs to providers on their secure ForwardHealth Portal accounts when at least one claim, adjustment request, or financial transaction is processed. RAs are generated from the appropriate ForwardHealth program when at least one claim, adjustment request, or financial transaction is processed. An RA is generated regardless of how a claim or adjustment is submitted (electronically or on paper). Generally, payment information is released and an RA is generated by ForwardHealth no sooner than the first state business day following the financial cycle.

Providers are required to access their secure ForwardHealth provider Portal account to obtain their RA.

RAs are accessible to providers in a TXT (text) format via the secure Provider area of the Portal. Providers are also able to download the RA from their secure provider Portal account in a CSV (comma-separated values) format.

Topic #5091

National Provider Identifier on the Remittance Advice

Health care providers who have a single NPI (National Provider Identifier) that is used for multiple enrollments will receive an RA for each enrollment 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 enrolled in Wisconsin 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.

Topic #4818

Calculating Totals on the Remittance Advice for Adjusted and Paid Claims

The total amounts for all adjusted or paid claims reported on the RA (Remittance Advice) appear at the end of the adjusted claims and paid claims sections. ForwardHealth calculates the total for each section by adding the net amounts for all claims listed in that section. 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 (Explanation of Benefits) codes and will not display an exact dollar amount.

Topic #534

Claim Number

Each claim or adjustment request received by ForwardHealth is assigned a unique claim number (also known as the ICN (internal

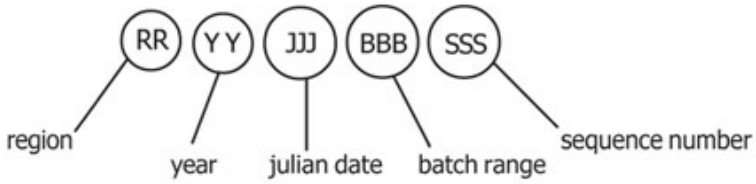
control number)). However, denied real-time compound and noncompound claims are not assigned an ICN, but receive an authorization number. Authorization numbers are not reported to the RA (Remittance Advice) or 835 (835 Health Care Claim Payment/Advice).

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.

Interpreting Claim Numbers

Each claim and adjustment received by ForwardHealth is assigned a unique claim number (also known as the internal control number or ICN). This number identifies valuable information about the claim and adjustment request. The following diagram and table provide detailed information about interpreting the claim number.



Type of Number and Description	Applicable Numbers and Description
Region — Two digits indicate the region. The region indicates how ForwardHealth received the claim or adjustment request.	10 — Paper Claims with No Attachments 11 — Paper Claims with Attachments 20 — Electronic Claims with No Attachments 21 — Electronic Claims with Attachments 22 — Internet Claims with No Attachments 23 — Internet Claims with Attachments 25 — Point-of-Service Claims 26 — Point-of-Service Claims with Attachments 40 — Claims Converted from Former Processing System 45 — Adjustments Converted from Former Processing System 50–59 — Adjustments 80 — Claim Resubmissions 90–91 — Claims Requiring Special Handling
Year — Two digits indicate the year ForwardHealth received the claim or adjustment 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 claim or adjustment request.	For example, February 3 would appear as 034.
Batch range — Three digits indicate the batch range assigned to the claim.	The batch range is used internally by ForwardHealth.
Sequence number — Three digits indicate the sequence number assigned within the batch range.	The sequence number is used internally by ForwardHealth.

Topic #535

Claim Status

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

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

Topic #4746

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 (Remittance Advice); the detail line EOB (Explanation of Benefits) codes inform providers that an amount was deducted from the total reimbursement but may not indicate the exact amount.

Note: Providers who receive 835 (835 Health Care Claim Payment/Advice) transactions will be able to see all deducted amounts on paid and adjusted claims.

Topic #537

Electronic Remittance Information

Providers are required to access their secure ForwardHealth provider Portal account to obtain their RAs (Remittance Advices). Electronic RAs on the Portal are not available to the following providers because these providers are not allowed to establish Portal accounts by their Provider Agreements:

- In-state emergency providers.
- Out-of-state providers.
- Out-of-country providers.

RAs are accessible to providers in a TXT (text) format or from a CSV (comma-separated values) file via the secure Provider area of the Portal.

Text File

The TXT format file is generated by financial payer and listed by RA number and RA date on the secure provider Portal account under the "View Remittance Advices" menu. RAs from the last 97 days are available in the TXT format. When a user clicks on an RA, a pop-up window displays asking if the user would like to "Open" or "Save" the file. If "Open" is chosen, the document opens

based on the user's application associated with opening text documents. If "Save" is chosen, the "Save As" window will open. The user can then browse to a location on their computer or network to save the document.

Users should be aware that "Word Wrap" must be turned off in the Notepad application. If it is not, it will cause distorted formatting. Also, users may need to resize the Notepad window in order to view all of the data. Providers wanting to print their files must ensure that the "Page Setup" application is set to the "Landscape" setting; otherwise the printed document will not contain all the information.

Comma-Separated Values Downloadable File

A CSV file is a file format accepted by a wide range of computer software programs. Downloadable CSV-formatted RAs allow users the benefits of building a customized RA specific to their use and saving the file to their computer. The CSV file on a provider's Portal appears as linear text separated by commas until it is downloaded into a compatible software program. Once downloaded, the file may be saved to a user's computer and the data manipulated, as desired.

To access the CSV file, providers should select the "View Remittance Advices" menu at the top of the provider's Portal home page.

The CSV files are generated per financial payer and listed by RA number and RA date. A separate CSV file is listed for the last 10 RAs. Providers can select specific sections of the RA by date to download making the information easy to read and organize.

The CSV file may be downloaded into a Microsoft Office Excel spreadsheet or into another compatible software program, such as Microsoft Office Access or OpenOffice 2.2.1. OpenOffice is a free software program obtainable from the Internet. Google Docs and ZDNet also offer free spreadsheet applications. Microsoft Office Excel, a widely used program, is a spreadsheet application for Microsoft Windows and Mac OS X. For maximum file capabilities when downloading the CSV file, the 1995 Office Excel for Windows (Version 7.0) included in Office 95 or a newer version is recommended. Earlier versions of Microsoft Office Excel will work with the CSV file; however, files exceeding 65,000 lines may need to be split into smaller files when downloading using earlier versions. Microsoft Office Access can manage larger data files.

Refer to the CSV User Guide on the Portal User Guides page of the Portal for instructions about Microsoft Office Excel functions that can be used to manipulate RA data downloaded from the CSV file.

835

Electronic remittance information may be obtained using the 835 (835 Health Care Claim Payment/Advice) 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 real-time compound or noncompound claim will not appear on remittance information if the claim is denied by ForwardHealth. ForwardHealth releases payment information to the 835 no sooner than on the first state business day following the financial cycle.

Provider Electronic Solutions Software

The DHCAA (Division of Health Care Access and Accountability) offers electronic billing software at no cost to the provider. The PES (Provider Electronic Solutions) software allows providers to download the 835 transaction. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Topic #4822

Explanation of Benefit Codes in the Claim Header and

in the Detail Lines

EOB (Explanation of Benefits) 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 (Remittance Advice) report EOBs for the claim header information and detail lines, as appropriate. Header information is a summary of the information from the claim, such as the DOS (date of service) 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.

TEXT File

EOB codes and descriptions are listed in the RA information in the TXT (text) file.

CSV File

EOB codes are listed in the RA information from the CSV (comma-separated values) file; however, the printed messages corresponding to the codes do not appear in the file. The EOB Code Listing matching standard EOB codes to explanation text is available on the Portal for reference.

Topic #13437

ForwardHealth-Initiated Claim Adjustments

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

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

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

Topic #4820

Identifying the Claims Reported on the Remittance Advice

The RA (Remittance Advice) reports the first 12 characters of the MRN (medical record number) and/or a PCN (patient control number), 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.

Topic #539

Obtaining the Remittance Advice

Providers are required to access their secure ForwardHealth provider Portal account to obtain RAs (Remittance Advice). The secure Portal allows providers to conduct business and exchange electronic transactions with ForwardHealth. A separate Portal account is required for each financial payer.

Providers who do not have a ForwardHealth provider Portal account may request one.

RAs are accessible to providers in a TXT (text) format via the secure provider Portal account. The TXT format file is generated per financial payer and listed by RA number and RA date on the secure provider Portal account under "View Remittance Advices" menu at the top of the provider's Portal home page. RAs from the last 97 days are available in the TXT format.

Providers can also access RAs in a CSV (comma-separated values) format from their secure provider Portal account. The CSV files are generated per financial payer and listed by RA number and RA date on the secure provider Portal account under "View Remittance Advices" menu at the top of the provider's Portal home page. A separate CSV file is listed for the last 10 RAs.

Topic #4745

Overview of Claims Processing Information on the Remittance Advice

The claims processing sections of the RA (Remittance Advice) 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.

Claim Types on the Remittance Advice and Corresponding Provider Types

Claim Types	Provider Types
Dental claims	Dentists, dental hygienists, HealthCheck agencies that provide dental services.
Drug and compound drug claims	Pharmacies and dispensing physicians.
Inpatient claims	Inpatient hospital providers and institutes for mental disease providers.
Long term care claims	Nursing homes.
Medicare crossover institutional claims	Most providers who submit claims on the UB-04.
Medicare crossover professional claims	Most providers who submit claims on the 1500 Health Insurance Claim Form.
Outpatient claims	Outpatient hospital providers and hospice providers.
Professional claims	Ambulance providers, ambulatory surgery centers, anesthesiologist assistants, audiologists, case management providers, certified registered nurse anesthetists, chiropractors, community care organizations, community support programs, crisis intervention providers, day treatment providers, family planning clinics, federally qualified health centers, HealthCheck providers, HealthCheck "Other Services" providers, hearing instrument specialists, home health agencies, independent labs, individual medical supply providers, medical equipment vendors, mental health/substance abuse clinics, nurses in independent practice, nurse practitioners, occupational therapists, opticians, optometrists, personal care agencies, physical therapists, physician assistants, physician clinics, physicians, podiatrists, portable X-ray providers, prenatal care coordination providers, psychologists, rehabilitation agencies, respiratory therapists, rural health clinics, school-based services providers, specialized medical vehicle providers, speech and hearing clinics, speech-language pathologists, therapy groups.

Topic #4821

Prior Authorization Number on the Remittance Advice

The RA (Remittance Advice) reports PA (prior authorization) numbers used to process the claim. PA numbers appear in the detail lines of claims processing information.

Topic #4418

Reading Non-Claims Processing Sections of the Remittance Advice

Address Page

In the TXT (text) file, the Address page displays the provider name and "Pay to" address of the provider.

Banner Messages

The Banner Messages section of the RA (Remittance Advice) 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; therefore, providers who receive multiple RAs should read all of their banner messages.

Banner messages appear on the TXT file, but not on the CSV (comma-separated values) file. Banner messages are posted in the "View Remittance Advices" menu on the provider's secure Portal account.

Explanation of Benefits Code Descriptions

EOB (Explanation of Benefits) code descriptions are listed in the RA information in the TXT file.

EOB codes are listed in the RA information from the CSV file; however, the printed messages corresponding to the codes do not appear in the file.

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 in the "Balance" column.

In the Accounts Receivable section, the "Amount Recouped In Current Cycle" column, when applicable, shows the recoupment amount for the financial cycle as a separate number from the "Recoupment Amount To Date." The "Recoupment Amount To Date" column shows the total amount recouped for each accounts receivable, *including* the amount recouped in the current cycle. The "Total Recoupment" *line* shows the sum of all recoupments to date in the "Recoupment Amount To Date" column and the sum of all recoupments for the current financial cycle in the "Amount Recouped In Current Cycle" column.

For each claim adjustment listed on the RA, a separate accounts receivable will be established and will be listed in the Financial Transactions section. The accounts receivable will be established for the entire amount of the original paid claim. This reflects the way ForwardHealth adjusts claims — by first recouping the entire amount of the original paid claim.

Each new claim adjustment is assigned an identification number called the "Adjustment ICN (internal control number)." 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	V — Capitation adjustment

type of financial transaction that created the accounts receivable.	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 (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)) 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 (Omnibus Budget Reconciliation Act of 1987) 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.

Topic #368

Reading the Claim Adjustments Section of the Remittance Advice

Providers receive a Claim Adjustments section in the RA (Remittance Advice) 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.

To adjust a claim, ForwardHealth recoups the *entire amount* of the original paid claim and calculates a new payment amount for

the claim adjustment. ForwardHealth does not recoup the *difference* — or pay the *difference* — between the original claim amount and the claim adjustment amount.

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

The Claim Adjustments section only lists detail lines for a claim adjustment if that claim adjustment has detail line EOBs. This section does not list detail lines for the original paid claim.

Note: For adjusted compound and noncompound 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." The response indicated depends on the difference between the original claim amount and the claim adjustment amount.

If the difference is a positive dollar amount, indicating that ForwardHealth owes additional monies to the provider, then the amount appears in the "Additional Payment" line.

If the difference is a negative dollar amount, indicating that the provider owes ForwardHealth additional monies, then the amount appears in the "Overpayment To Be Withheld" line. 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.

Topic #4824

Reading the Claims Denied Section of the Remittance Advice

Providers receive a Claims Denied section in the RA (Remittance Advice) 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 (Explanation of Benefits) 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.

Sample Professional Services Claims Denied Section of the Remittance Advice

Remittance Advice — Professional Service Claims Denied Sample

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REPORT:   CRA-HCDN-R                                      FORWARDHEALTH INTERCHANGE                                  DATE:  MM/DD/CCYY
   RA#:   999999999                                     <Financial Cycle Description>                                PAGE:       9,999
 PAYER:   XXXX                                           PROVIDER REMITTANCE ADVICE
                                                      PROFESSIONAL SERVICE CLAIMS DENIED

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                      PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                         NPI                 9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                         CHECK/EFT NUMBER     999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                         PAYMENT DATE       MM/DD/CCYY

  --ICN--         PCN           MRN        SERVICE DATES    BILLED          OTH INS         SPENDDOWN
                                            FROM   TO       AMOUNT          AMOUNT          AMOUNT

MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS  XXXXXXXXXXXX  XXXXXXXXXXXX  MMDDYY MMDDYY  999,999,999.99   9,999,999.99    999,999.99


HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999


                                 SERVICE DATES                      PA NUMBER
PROC CD  MODIFIERS   ALLW UNITS  FROM   TO     RENDERING PROVIDER   BILLED AMT     DETAIL EOBS
 XXXXX  XX XX XX XX   9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX  XXXXXXXXXX     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                    9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX  XX XX XX XX   9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX  XXXXXXXXXX     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                    9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX  XX XX XX XX   9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX  XXXXXXXXXX     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                    9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX  XX XX XX XX   9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX  XXXXXXXXXX     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                    9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999



            TOTAL PROFESSIONAL SERVICE CLAIMS DENIED:  9,999,999,999.99  99,999,999.99  9,999,999.99
TOTAL NO. DENIED:  999,999
```

Topic #4825

Reading the Claims Paid Section of the Remittance Advice

Providers receive a Claims Paid section in the RA (Remittance Advice) 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 (Explanation of Benefits) 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.

Sample Professional Services Claims Paid Section of the Remittance Advice

Remittance Advice — Professional Service Claims Paid Sample

```
REPORT:   CRA-HCPD-R                                      FORWARDHEALTH INTERCHANGE                             DATE:  MM/DD/CCYY
  RA#:    999999999                                     <Financial Cycle Description>                           PAGE:       9,999
 PAYER:   XXXX                                           PROVIDER REMITTANCE ADVICE
                                                        PROFESSIONAL SERVICE CLAIMS PAID

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                         PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                            NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                            CHECK/EFT NUMBER    999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                             PAYMENT DATE       MM/DD/CCYY


  --ICN--         PCN           MRN        SERVICE DATES      BILLED AMT       OTH INS AMT    COPAY AMT        PAID AMT
                                           FROM    TO        ALLOWED AMT     SPENDDOWN AMT    CO-INS CB       OUTPAT DED

MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS  XXXXXXXXXXXX  XXXXXXXXXXXX  MMDDYY MMDDYY    9,999,999.99     9,999,999.99     999,999.99     9,999,999.99
                                                            9,999,999.99       999,999.99     999,999.99       999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                     SERVICE DATES ALLW UNITS RENDERING PROVIDER        PA NUMBER
PROC CD  MODIFIERS   FROM    TO    COPAY AMT  BILLED AMT   ALLOWED AMT  PAID AMT     DETAIL EOBS
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999


             TOTAL PROFESSIONAL SERVICE CLAIMS PAID:       99,999,999.99    99,999,999.99   9,999,999.99    99,999,999.99
                                                           99,999,999.99     9,999,999.99   9,999,999.99     9,999,999.99
TOTAL NO. PAID: 999,999
```

Topic #4828

Remittance Advice Financial Cycles

Each financial payer (Medicaid, WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program)) has separate financial cycles that occur on different days of the week. RAs (Remittance Advices) are generated and posted to secure provider Portal accounts after each financial cycle is completed. Therefore, RAs may be generated and posted to secure provider ForwardHealth Portal accounts 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 have access to the RAs generated and posted to secure provider Portal accounts for these financial transactions at any time during the week.

Topic #4827

Remittance Advice Generated by Payer and by Provider Enrollment

RAs (Remittance Advices) are generated and posted to secure provider Portal accounts 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 (Wisconsin Chronic Disease Program).
- WWWP (Wisconsin Well Woman Program).

A separate Portal account is required for each financial payer.

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 enrollment. Providers who have a single NPI (National Provider Identifier) that is used for multiple enrollments should be aware that an RA will be generated for each enrollment, 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 enrolled 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.

Topic #6237

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 (National Provider Identifier) and 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 (Remittance Advice).)
- 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
313 Blettner Blvd
Madison WI 53784

Topic #5018

Searching for and Viewing All Claims on the Portal

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

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

- Go to the Portal.
- Log in to the secure Provider area of the Portal.
- The most recent claims processed by ForwardHealth will be viewable on the provider's home page or the provider may

select "claim search" and enter the applicable information to search for additional claims.
- Select the claim the provider wants to view.

Topic #4829

Sections of the Remittance Advice

The RA (Remittance Advice) information in the TXT (text) file includes the following sections:

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

The RA information in the CSV (comma-separated values) file includes the following sections:

- Payment.
- Payment hold.
- Service codes and descriptions.
- Financial transactions.
- Summary.
- Inpatient claims.
- Outpatient claims.
- Professional claims.
- Medicare crossovers — Professional.
- Medicare crossovers — Institutional.
- Compound drug claims.
- Drug claims.
- Dental claims.
- Long term care claims.
- Financial transactions.
- Summary.

Providers can select specific sections of the RA in the CSV file within each RA date to be downloaded making the information easy to read and to organize.

Remittance Advice Header Information

The first page of each section of the RA (except the address page of the TXT file) 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 (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)).
- 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 and date 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 (National Provider Identifier).
- 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.

Topic #544

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

Topic #516

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.

Topic #366

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.

Topic #548

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 (Department of Health Services).
- 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 (General Relief).
- 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.

Topic #547

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 (date of service). 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).

Topic #517

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, ForwardHealth automatically deducts the copayment amount.

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

Submission

Topic #4455

1500 Health Insurance Claim Form Completion Instructions for a Telemedicine Originating Site Fee

A sample 1500 Health Insurance Claim Form is available for telemedicine originating site services.

Use the following claim form completion instructions, not the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Complete all required elements as appropriate. Be advised tht every code used, even if it is entered in a non-required element, is required to be a valid code. Do not include attachments unless instructed to do so.

Members enrolled in BadgerCare Plus or Medicaid receive a ForwardHealth identification card. 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.

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

Submit completed paper claims to the following address:

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

Element 1 — Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Blk Lung, Other
Enter "X" in the Medicaid check box.

Element 1a — Insured's ID Number
Enter the member identification number. Do not enter any other numbers or letters. Use the FowardHealth card or Wisconsin's EVS (Enrollment Verification System) to obtain the correct member ID.

Element 2 — Patient's Name
Enter the member's last name, 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 3 — Patient's Birth Date, Sex
Enter the member's birth date in MMDDYY format (e.g., February 3, 1955, would be 020355) or in MMDDCCYY format (e.g., February 3, 1955, would be 02031955). Specify whether the member is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name
Data are required in this element for OCR (Optical Character Recognition) 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.

Element 5 — Patient's Address
Enter the complete address of the member?s place of residence, if known.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name
Commercial health insurance must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth.

If the EVS indicates that the member has dental ("DEN") insurance only, is enrolled in a Medicare Advantage Plan only, or has any other commercial health insurance, and the service requires other insurance billing, one of the following three OI (other insurance) explanation codes must be indicated in the first box of Element 9. If submitting a multiple-page claim, providers are required to indicate OI explanation codes on the *first page* of the claim.

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

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	• YES, the member has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to, the following: • The member denied coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • The member's commercial health insurance failed to respond to initial and follow-up claims. • Benefits are not assignable or cannot get assignment. • Benefits are exhausted.

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

Element 9a — Other Insured's Policy or Group Number (not required)

Element 9b — Other Insured's Date of Birth, Sex (not required)

Element 9c — Employer's Name or School Name (not required)

Element 9d — Insurance Plan Name or Program Name (not required)

Element 10a-10c — Is Patient's Condition Related to: (not required)

Element 10d — Reserved for Local Use (not required)

Element 11 — Insured's Policy Group or FECA Number
If an EOMB (Explanation of Medicare Benefits) indicates that the member is enrolled in a Medicare Advantage Plan and the claim is being billed as a crossover, enter "MMC" in the upper right corner of the claim, indicating that the other insurance is a Medicare Advantage Plan and the claim should be processed as a crossover claim.

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

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

If none of the previous statements are true, a Medicare disclaimer code is necessary. If submitting a multiple-page claim, indicate Medicare disclaimer codes on the *first page* of the claim. The following Medicare disclaimer codes may be used when appropriate.

Code	Description
M-7	**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. *For Medicare Part A, use M-7 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as enrolled in Medicare Part A. • The member is eligible for Medicare Part A. • The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or exhausted benefits. *For Medicare Part B, use M-7 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as enrolled in Medicare Part B. • The member is eligible for Medicare Part B. • The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or exhausted benefits.
M-8	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. *For Medicare Part A, use M-8 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as enrolled in Medicare Part A. • The member is eligible for Medicare Part A. • The service is usually covered by Medicare Part A but not in this circumstance (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 enrolled in Medicare Part B.
- The member is eligible for Medicare Part B.
- The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis).

Element 11a — Insured's Date of Birth, Sex (not required)

Element 11b — Employer's Name or School Name (not required)

Element 11c — Insurance Plan Name or Program Name (not required)

Element 11d — Is there another Health Benefit Plan? (not required)

Element 12 — Patient's or Authorized Person's Signature (not required)

Element 13 — Insured's or Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Element 17 — Name of Referring Provider or Other Source (not required)

Element 17a — (not required)

Element 17b — NPI (not required)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use
If a provider bills an unlisted (or not otherwise classified) procedure code, a description of the procedure must be indicated in this element. If there is no more specific code available, the provider is required to submit the appropriate documentation, which could include a PA (prior authorization) request, to justify use of the unlisted procedure code and to describe the procedure or service rendered.

Element 20 — Outside Lab? $Charges (not required)

Element 21 — Diagnosis or Nature of Illness or Injury
Enter a valid ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis code for each symptom or condition related to the services provided. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

ForwardHealth accepts up to eight diagnosis codes. To enter more than four diagnosis codes:

- Enter the fifth diagnosis code in the space *between* the first and third diagnosis codes.
- Enter the sixth diagnosis code in the space *between* the second and fourth diagnosis codes.
- Enter the seventh diagnosis code in the space to the right of the third diagnosis code.
- Enter the eighth diagnosis code in the space to the right of the fourth diagnosis code.

When entering fifth, sixth, seventh, and eighth diagnosis codes, do not number the diagnosis codes (e.g., do not include a "5."

before the fifth diagnosis code).

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

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

Element 24A — Date(s) of Service
Enter to and from dates of service (DOS) in MMDDYY or MMDDCCYY format. If the service was provided on only one DOS, enter the date under "From." Leave "To" blank or re-enter the "From" date.

If the service was provided on consecutive days, those dates may be indicated as a range of dates by entering the first date as the "From" DOS and the last date as the "To" DOS in MMDDYY or MMDDCCYY format.

A range of dates may be indicated only if the POS (place of service), the procedure code (and modifiers, if applicable), the charge, the units, and the rendering provider were identical for each DOS within the range.

Element 24B — Place of Service
Enter the appropriate two-digit POS code for each item used or service performed.

Element 24C — EMG
Enter a "Y" for each procedure performed as an emergency. If the procedure was not an emergency, leave this element blank.

Element 24D — Procedures, Services, or Supplies
Enter the single most appropriate five-character procedure code. ForwardHealth denies claims received without an appropriate procedure code.

Modifiers
Enter the appropriate (up to four per procedure code) modifier(s) in the "Modifier" column of Element 24D.

Element 24E — Diagnosis Pointer
Enter the number(s) that corresponds to the appropriate ICD-9-CM diagnosis code(s) listed in Element 21. Up to four diagnosis pointers per detail may be indicated. Valid diagnosis pointers, digits 1 through 8, should *not* be separated by commas or spaces.

Element 24F — $ Charges
Enter the total charge for each line item.

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

Providers are to bill ForwardHealth their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to ForwardHealth benefits.

Element 24G — Days or Units
|Enter the number of days or units. Only include a decimal when billing fractions (e.g., 1.50).

Element 24H — EPSDT/Family Plan (not required)

Element 24I — ID Qual (not required)

Element 24J — Rendering Provider ID. # (not required)

Element 25 — Federal Tax ID Number (not required)

Element 26 — Patient's Account No. (not required)
Optional — Providers may enter up to 14 characters of the patient's internal office account number. This number will appear on the Remittance Advice and/or the 835 Health Care Claim Payment/Advice transaction.

Element 27 — Accept Assignment? (not required)

Element 28 — Total Charge
Enter the total charges for this claim. 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*.

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

Element 29 — Amount Paid
Enter the actual amount paid by commercial health insurance. If submitting a multiple-page claim, indicate the amount paid by commercial health insurance only on the *first page* of the claim.

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

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

Element 30 — Balance Due
Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28. If submitting a multiple-page claim, enter the balance due for the claim (i.e., the sum of all details from all pages of the claim minus the amount paid by commercial insurance) *only on the last page of the claim*.

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

Element 31 — Signature of Physician or Supplier, Including Degrees or Credentials
The provider or authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MMDDYY or MMDDCCYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 — Service Facility Location Information (not required)

Element 32a — NPI (not required)

Element 32b — (not required)

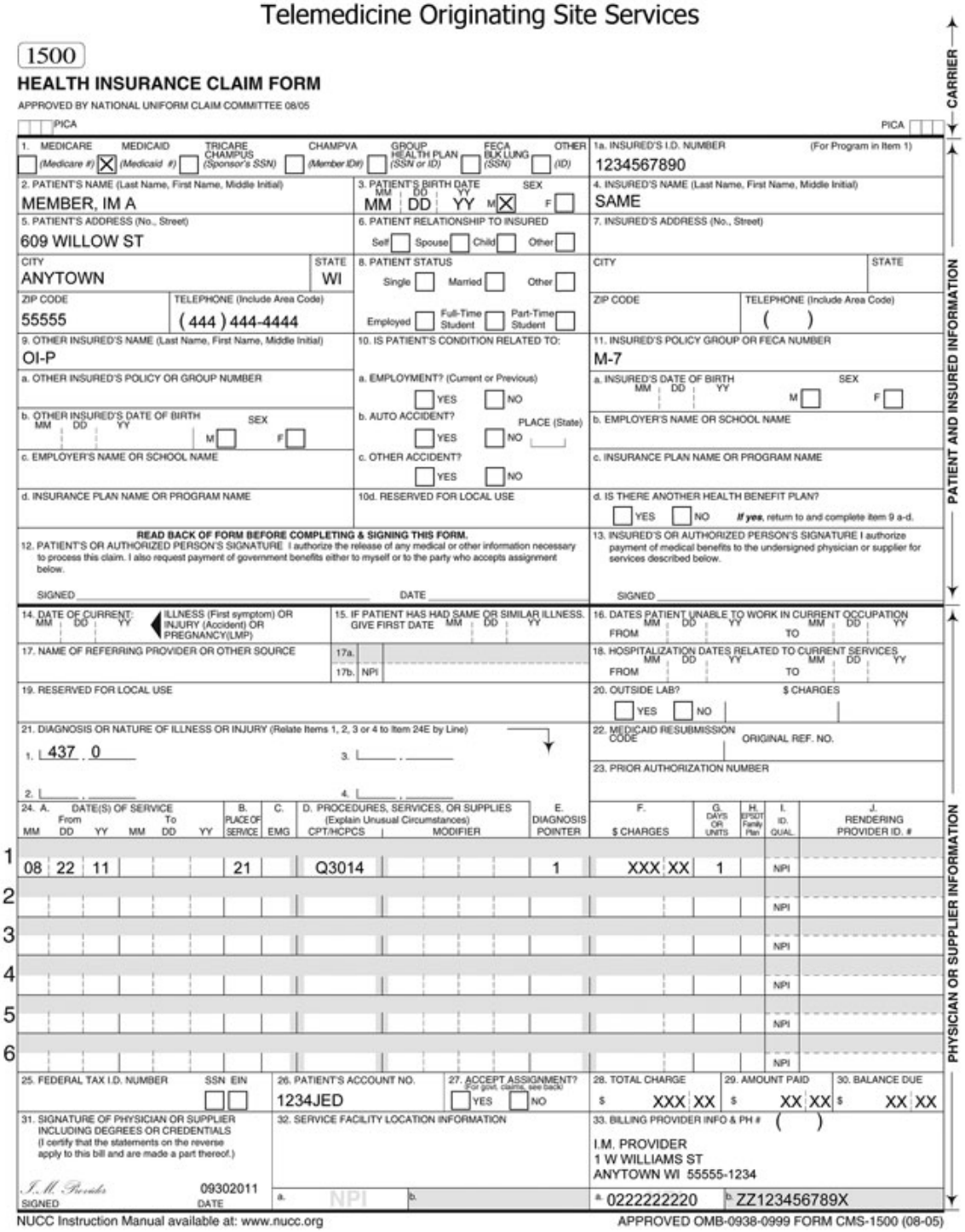
Element 33 — Billing Provider Info & Ph #
Enter the name of the provider submitting the claim and the practice location address. The minimum requirement is the provider's name, street, city, state, and ZIP+4 code. Do not enter a Post Office Box or a ZIP+4 code associated with a PO Box. The practice location address entered must correspond with the NPI listed in Element 33a and match the practice location on the provider's file maintained by ForwardHealth

Element 33a — NPI
Enter the NPI of the billing provider.

Element 33b
Enter qualifier "ZZ" followed by the appropriate 10-digit provider taxonomy code on file with ForwardHealth. Do not include a space between the qualifier ("ZZ") and the provider taxonomy code.

Note: Providers should use qualifier "PXC" when submitting an electronic claim using the 837P (837 Health Care Claim: Professional) transaction. For further instructions, refer to the companion guide for the 837P transaction.

Sample 1500 Health Insurance Claim Form for Telemedicine Originating Site Services



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID [X] (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MEMBER, IM A	3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY; SEX: M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME
5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street):
CITY: ANYTOWN; STATE: WI	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]	CITY: ; STATE:
ZIP CODE: 55555; TELEPHONE (Include Area Code): (444) 444-4444	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE: ; TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: M-7
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]	a. INSURED'S DATE OF BIRTH MM DD YY; SEX: M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX: M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. ; 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. L 437 . 0 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	08 22 11		21		Q3014		1	XXX XX	1		NPI	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]	26. PATIENT'S ACCOUNT NO. 1234JED	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]	28. TOTAL CHARGE $ XXX XX
29. AMOUNT PAID $ XX XX	30. BALANCE DUE $ XX XX		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Provider SIGNED 09302011 DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234 a. 0222222220 b. ZZ123456789X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Topic #10677

Advanced Imaging Services

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

Submitting Claims for Situations Exempt from the Prior Authorization Requirement

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

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

Service Provided During an Inpatient Stay

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

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

Service Provided for Observation Status

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

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

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

Service Provided as Part of Emergency Room Visit

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

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

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

Service Provided as Emergency Service

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

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

guide for instructions on including a modifier.

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

Topic #542

Attached Documentation

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

Topic #6957

Copy Claims on the ForwardHealth Portal

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

Topic #5017

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

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

Topic #1353

Dilation and Curettage

When submitting claims for dilation and curettage surgical procedures, hospitals are required to attach a copy of the preoperative history and physical exam document and an operative and pathology report with the UB-04 Claim Form.

Topic #4997

Direct Data Entry of Professional and Institutional Claims on the Portal

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

- Professional claims.
- Institutional claims.
- Dental claims.

- Compound drug claims.
- Noncompound drug claims.

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

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

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

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

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

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

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

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

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

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

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

Topic #344

Electronic Claim Submission

Providers are encouraged to submit claims electronically. Electronic claim 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.

Topic #1433

Electronic claims for inpatient hospital services must be submitted using the 837I (837 Health Care Claim: Institutional) transaction. Claims for inpatient hospital services submitted using any transaction other than the 837I will be denied.

Providers should use the companion guide for the 837I transaction when submitting these claims.

Provider Electronic Solutions Software

The DHCAA (Division of Health Care Access and Accountability) offers electronic billing software at no cost to providers. The PES (Provider Electronic Solutions) software allows providers to submit electronic claims using an 837 transaction. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Topic #365

Extraordinary Claims

Extraordinary claims are claims that have been denied by a BadgerCare Plus HMO (health maintenance organization) or SSI (Supplemental Security Income) HMO and should be submitted to fee-for-service.

Topic #4837

HIPAA-Compliant Data Requirements

Procedure Codes

All fields submitted on paper and electronic claims are edited to ensure HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance before being processed. Compliant code sets include CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) procedure codes entered into all fields, including those fields that are "Not Required" or "Optional."

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

Provider Numbers

For health care providers, NPIs (National Provider Identifiers) are required in all provider number fields on paper claims and 837 (837 Health Care Claim) transactions, including rendering, billing, referring, prescribing, attending, and "Other" provider fields.

Non-healthcare providers, including personal care providers, SMV (specialized medical vehicle) providers, blood banks, and CCOs (community care organizations) should enter valid provider numbers into fields that require a provider number.

Topic #1432

Leaves of Absence

Member leaves of absence from an inpatient hospital are not covered. Use revenue code 180 for all days the member was not present at the midnight census. Indicate the total leave days in Form Locator 46 (units) of the UB-04 Claim Form.

Topic #562

Managed Care Organizations

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

Topic #1431

Multiple Page Claims

Multiple page claims are accepted for inpatient hospital stays. Providers should refer to the UB-04 (CMS 1450) Claim Form Instructions for Inpatient Hospital Services for more information on submitting multiple page claims.

Topic #367

Non-enrolled In-State Providers

Claims from non-enrolled in-state providers must meet additional requirements.

Topic #1430

Noncovered Days and Noncovered Charges

For hospital admissions, the entire length of stay is required to be shown in the "Statement Covers Period" even if the member is not enrolled during the entire stay, or if part of the stay is not covered. Wisconsin Medicaid does not reimburse the date of discharge; while the date of discharge is indicated in Form Locator 6 of the UB-04 Claim Form, it should not be counted in Form Locator 7.

Topic #10837

Note Field for Most Claims Submitted Electronically

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

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

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

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

- Professional.
- Institutional.
- Dental.

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

Claims Submitted Via 837 Health Care Claim Transactions

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

Topic #1352

One-Day Mother/Baby Stay

To appropriately be reimbursed for a one-day mother/baby stay, providers are required to submit a UB-04 inpatient claim form for the mother or the baby by following these procedures:

- Indicate bill type "111" for inpatient services in Form Locator 4.
- Indicate the "From" and "To" dates in Item 6 (they must be the same).

The diagnosis codes and procedure codes must result in the claim being assigned to one of the DRGs (diagnosis related groups) in range 767-768 or 774-776 (newborn) or any delivery including Cesarean section transfers.

Topic #561

Paper Claim Form Preparation and Data Alignment Requirements

Optical Character Recognition

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

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

Speed and Accuracy of Claims Processing

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

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

Handwritten Claims

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

Use Original Claim Forms

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

Use Laser or Ink Jet Printers

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

Alignment

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

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

The following sample claim forms demonstrate correct and incorrect alignment:

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

Clarity

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

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

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

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

Staples, Correction Liquid, and Correction Tape

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

Additional Diagnosis Codes

ForwardHealth will accept up to 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.

Sample of a Correctly Aligned 1500 Health Insurance Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

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

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

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M ☐ F ☒

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

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

CITY: ANYTOWN STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

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

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

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

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

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

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

17a.

17b. NPI 0111111110

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. XXX . X 3. . 2. . 4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.: 1234JED

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

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $ XX XX

30. BALANCE DUE: $ XX XX

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

I.M. Provider SIGNED MMDDCCYY DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

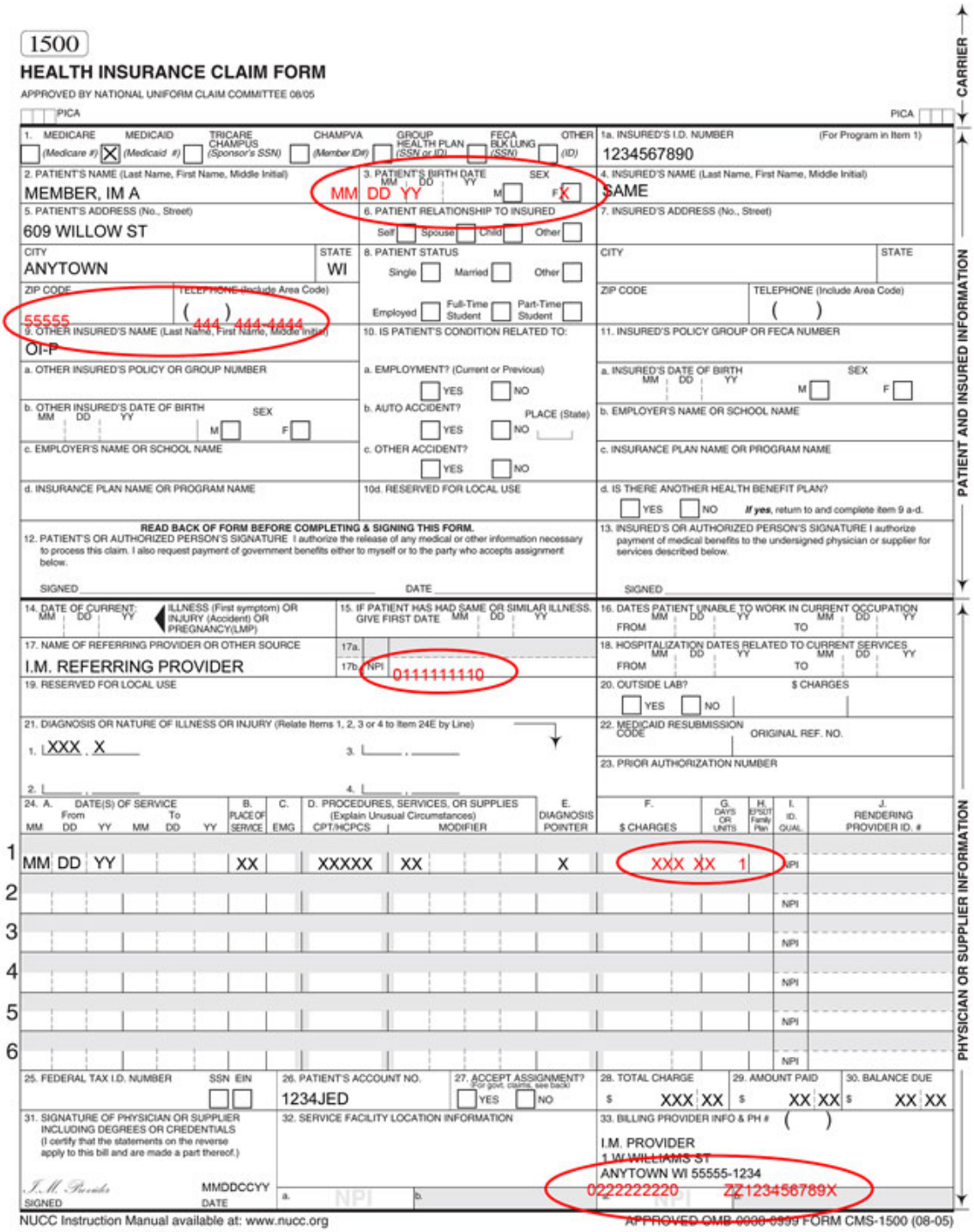
I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234

a. 0222222220 b. ZZ123456789X

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Sample of an Incorrectly Aligned 1500 Health Insurance Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

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

CITY: ANYTOWN | STATE: WI

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

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

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

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

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

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

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

17a.

17b. NPI 0111111110

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. XXX . X 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. 1234JED

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

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $ XX XX

30. BALANCE DUE $ XX XX

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

I.M. Provider SIGNED MMDDCCYY DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

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

PATIENT AND INSURED INFORMATION

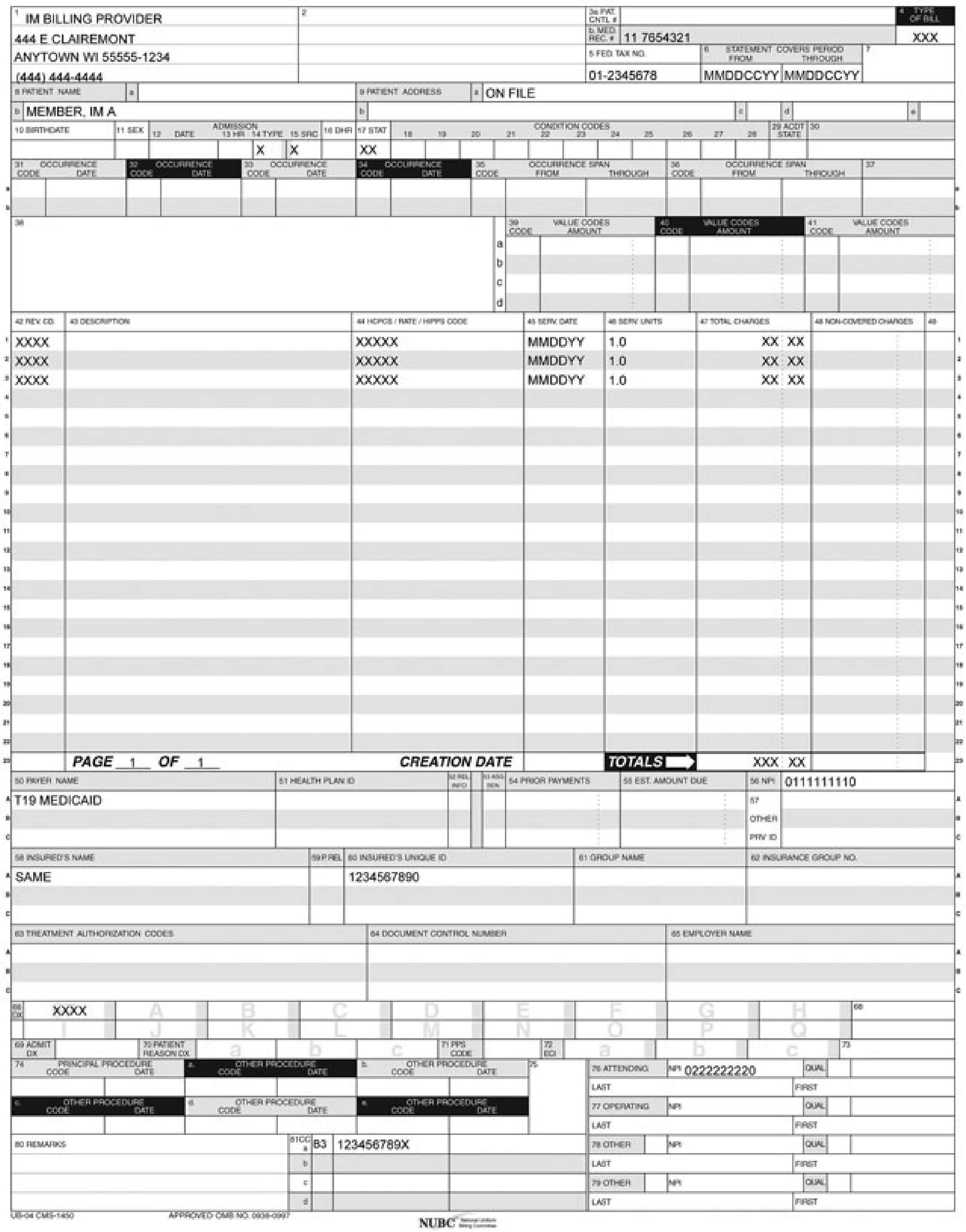
PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08-05)

Sample of a Correctly Aligned UB-04 Claim Form



1 IM BILLING PROVIDER
444 E CLAIREMONT
ANYTOWN WI 55555-1234
(444) 444-4444

3a PAT. CNTL #
b. MED. REC. # 11 7654321

4 TYPE OF BILL: XXX

5 FED. TAX NO.: 01-2345678

6 STATEMENT COVERS PERIOD FROM: MMDDCCYY THROUGH: MMDDCCYY

8 PATIENT NAME: b MEMBER, IM A

9 PATIENT ADDRESS: a ON FILE

14 TYPE: X 15 SRC: X 17 STAT: XX

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
XXXX		XXXXX	MMDDYY	1.0	XX XX	
XXXX		XXXXX	MMDDYY	1.0	XX XX	
XXXX		XXXXX	MMDDYY	1.0	XX XX	
PAGE 1 OF 1		CREATION DATE		TOTALS	XXX XX	

50 PAYER NAME: A T19 MEDICAID

56 NPI: 0111111110

58 INSURED'S NAME: A SAME

60 INSURED'S UNIQUE ID: 1234567890

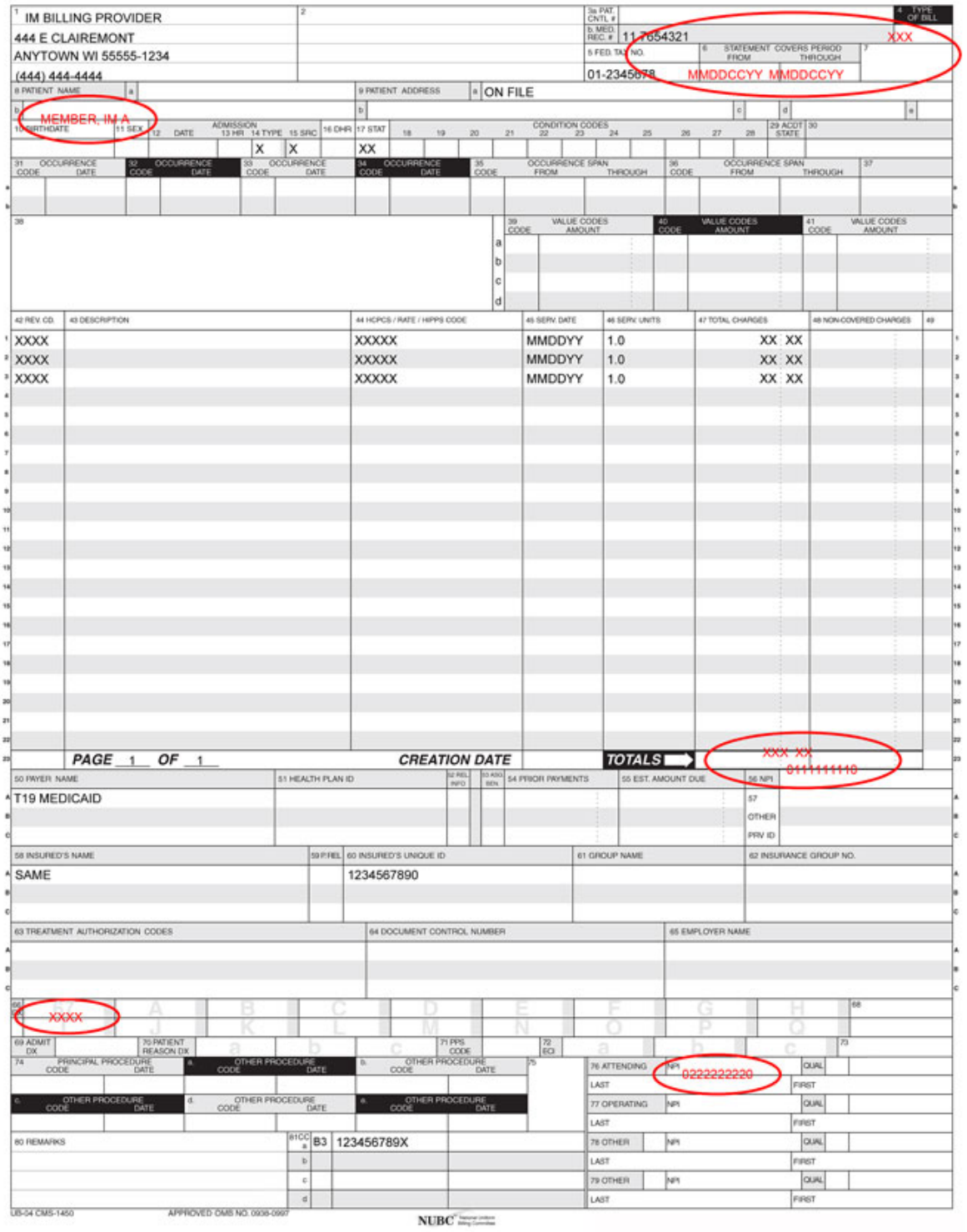
67 (DX): XXXX

76 ATTENDING NPI: 0222222220

81CC a: B3 123456789X

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee

Sample of an Incorrectly Aligned UB-04 Claim Form



Topic #1429

Paper Claim Submission

Paper claims for inpatient hospital services must be submitted using the UB-04 Claim Form. Claims for inpatient hospital services submitted on any other claim form are denied.

Providers should use the appropriate claim form instructions for inpatient hospital services when submitting these claims.

Obtaining the Claim Forms

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

Topic #1428

Patient Status Codes

The following patient status codes are accepted on claims submitted by inpatient hospital providers in most instances.

Patient Status Code	Description
21	Discharged/transferred to court/law enforcement.
43	Discharged/transferred to a federal health care facility.
61	Discharged/transferred to hospital-based Medicare approved swing bed.
62	Discharged/transferred to an IRF (inpatient rehabilitation facility) including rehabilitation distinct part units of a hospital.
63	Discharged/transferred to a Medicare LTCH (long term care hospital).
64	Discharged/transferred to a nursing facility enrolled in Medicaid but not enrolled in Medicare.
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
66	Discharged/transferred to critical access hospital.

Refer to the National UB-04 Uniform Billing Manual for a complete list of all nationally defined patient status codes.

All Patient Status Codes Valid for Inpatient Hospital Claims

For inpatient hospitals, all of the patient status codes listed in the chart are valid for both Medicare crossover claims and claims submitted only to ForwardHealth.

Wisconsin Medicaid Does Not Accept Patient Status Codes Reserved for National Assignment

Wisconsin Medicaid no longer accepts the following patient status codes that were redefined as "reserved for national assignment" by the National Uniform Billing Committee: 10-19, 22-29, 31-39, 44-49, 52-60, and 66-99.

Topic #1427

Point of Origin for Admission or Visit

Providers may refer to the National UB-04 Uniform Billing Manual for a complete list of all nationally defined Patient Status and Point of Origin for Admission or Visit codes.

Topic #8257

Present on Admission Indicator

All inpatient hospital providers are required to include POA (present on admission) indicator information for all primary and secondary diagnoses.

The DRA (Deficit Reduction Act) of 2005 requires a quality adjustment in MS-DRG (Medicare Severity Diagnosis Related Group) payments for certain HACs (hospital-acquired conditions). Wisconsin Medicaid and BadgerCare Plus are adopting the HACs established by the CMS (Centers for Medicare and Medicaid Services) and reflected in the MS-DRG payments. Reimbursement may be affected by this information. Refer to the CMS Web site for the list of HACs that may affect reimbursement.

Present on Admission Indicator Options and Definitions

The following are POA indicator options and corresponding definitions:

- Y: This indicates that the diagnosis was present at the time of inpatient admission.
- N: This indicates that the diagnosis was not present at the time of inpatient admission.
- U: This indicates that the documentation is insufficient to determine if the condition was present at the time of inpatient admission.
- W: This indicates that the provider is unable to clinically determine whether the condition was present at the time of inpatient admission.

Topic #10177

Prior Authorization Numbers on Claims

Providers are not required to indicate a PA (prior authorization) number on claims. ForwardHealth interChange matches the claim with the appropriate approved PA request. ForwardHealth's RA (Remittance Advice) and the 835 (835 Health Care Claim Payment/Advice) report to the provider the PA number used to process a claim. If a PA number is indicated on a claim, it will not be used and it will have no effect on processing the claim.

When a PA requirement is added to the list of drugs requiring PA and the effective date of a PA falls in the middle of a billing period, two separate claims that coincide with the presence of PA for the drug must be submitted to ForwardHealth.

Topic #13337

Professional Services

Certain professional and other services are excluded from the inpatient hospital diagnosis-related group payment system and from the outpatient hospital rate per visit reimbursement.

Claims for the following services or services provided by the following providers must be billed on a professional claim by a separately enrolled provider:

- Air, water, and land ambulance.
- Anesthesia assistants.
- Audiologists.

- CRNA (Certified registered nurse anesthetists).
- Chiropractors.
- Dentists.
- Hearing aid dealers.
- Independent nurse practitioners.
- Providers of medical equipment and supplies for non-hospital use.
- Nurse midwives.
- Occupational therapy.
- Optometrists.
- Physical therapy.
- Physicians.
- Physician assistants.
- Podiatrists.
- Psychiatrists.
- Psychologists.
- SMV (Specialized Medical Vehicle) providers.
- Speech-language pathology

Topic #10637

Reimbursement Reduction for Most Paper Claims

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

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

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

The reimbursement reduction applies to the following paper claims:

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

Exceptions to Paper Claim Reimbursement Reduction

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

- In-state emergency providers.
- Out-of-state providers.
- Medicare crossover claims.
- Any claims that ForwardHealth requires additional supporting information to be submitted on paper. For example:
    - Hysterectomy claims must be submitted along with a paper Acknowledgment of Receipt of Hysterectomy Information (F-1160A (10/08)) form.
    - Sterilization claims must be submitted along with a paper Consent for Sterilization (F-1164 (10/08)) form.
    - Claims submitted to Timely Filing appeals must be submitted on paper with a Timely Filing Appeals Request (F-13047 (07/12)) form.

- In certain circumstances, drug claims must be submitted on paper with a Pharmacy Special Handling Request (F-13074 (07/12)) form.

Topic #4817

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 guides 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 (F-13470 (10/08)). Providers are required to indicate an ACN (attachment control number) 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
313 Blettner Blvd
Madison WI 53784

This does not apply to compound and noncompound claims.

Topic #1403

Transfers Between Institutions for Mental Disease Hospitals and Acute Care General Hospitals

An inpatient at an IMD (institution for mental disease) may transfer to an acute care general hospital, then return to the IMD and eventually be discharged from the IMD. If the patient's absence from the IMD and simultaneous stay at the acute care general hospital is three or fewer consecutive days, Wisconsin Medicaid reimburses the IMD for one DRG (Diagnosis-Related Group) discharge payment. The member's payment covers the period before and the period after the stay at the acute care general hospital.

If the patient does not return to the IMD after the acute care general hospital stay, Wisconsin Medicaid reimburses the IMD one DRG payment for the patient's stay prior to his or her transfer to the acute care general hospital.

Three or fewer consecutive days means the patient is absent or on leave from the IMD for three or fewer consecutive IMD midnight census counts.

If the patient's stay at the acute care general hospital is more than three consecutive days, Wisconsin Medicaid reimburses the IMD with one DRG discharge payment for the patient's stay at the IMD prior to going to the acute care general hospital. If the patient returns to the IMD, Wisconsin Medicaid reimburses the IMD a second DRG discharge payment for the period after the acute care general hospital stay. In this situation, the IMD must separately bill for the two periods so that the IMD may receive

two DRG discharge payments.

Wisconsin Medicaid reimburses the acute care hospital to which the patient was transferred for the medically necessary stay without regard to the patient's length of stay. The acute care hospital is paid a DRG discharge payment without regard to which condition described above applies to the IMD.

Any payment to the IMD for a patient's stay is subject to the person's coverage for their stay at the IMD.

Topic #1426

Transfers Between Units Within a Hospital

Patients who are transferred from one hospital unit to another within the same hospital are not considered discharged until the entire hospital stay has ended. A discharge occurs when the patient leaves the hospital for any reason other than a "leave of absence." Wisconsin Medicaid pays hospitals one DRG (Diagnosis-Related Group) per stay and does not recognize specialty rehabilitation or psychiatric units for separate reimbursement purposes.

Topic #3448

UB-04 (CMS 1450) Claim Form Instructions for Inpatient Hospital Services

A sample UB-04 Claim Form is available for inpatient hospital services.

These instructions are for the completion of the UB-04 claim for ForwardHealth. For complete billing instructions, refer to the National UB-04 Uniform Billing Manual prepared by the NUBC (National Uniform Billing Committee). 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.

Members enrolled in BadgerCare Plus or Medicaid receive a ForwardHealth identification card. 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.

Note: Every code used on this claim form, even if the code is entered in a non-required form locator, is required to be a valid code. In addition, 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
313 Blettner Blvd
Madison WI 53784

Form Locator 1 — Provider Name, Address, and Telephone Number
Enter the name of the hospital submitting the claim and the hospital's complete practice location address. The minimum requirement is the hospital's name, city, state, and ZIP+4 code. Do not enter a Post Office Box or a ZIP+4 code associated with a PO Box. The name in Form Locator 1 must correspond with the NPI (National Provider Identifier) 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 the RA (Remittance Advice) and/or the 835 (835 Health Care Claim Payment/Advice) transaction.

Form Locator 3b — Med. Rec. #
Enter the number assigned to the patient's medical/health record by the provider. This number will appear on the RA and/or the 835 transaction.

Form Locator 4 — Type of Bill
Exclude the leading zero and enter the three-digit type of bill code. The type of bill codes for inpatient hospital services include the following:

- 111 = Hospital, inpatient, admit through discharge claim.
- 851 = Special facility, critical access hospital, admit through discharge claim.

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

Form Locator 6 — Statement Covers Period (From - Through)
Enter both dates in MMDDYY format (e.g., November 3, 2008, would be 110308). Include the date of discharge or death.

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 (Enrollment Verification System) 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 are required in this form locator for OCR processing. Any information populated by a provider's computer software is acceptable data for this form locator (e.g., "On file"). If computer software does not automatically complete this form locator, enter information such as the member's complete address in field 9a.

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 (not required)

Form Locator 12 — Admission/Start of Care Date
Enter the admission date in MMDDYY format (e.g., November 3, 2008, would be 110308).

Form Locator 13 — Admission Hr (not required)

Form Locator 14 — Priority (Type) of Admission or Visit
Enter the appropriate admission type for the services rendered. Refer to the UB-04 Billing Manual for more information.

Form Locator 15 — Point of Origin for Admission or Visit
Enter the code indicating the source of this admission. Refer to the UB-04 Billing Manual for more information.

Form Locator 16 — DHR (not required)

Form Locator 17 — Patient Discharge Status
Enter the code indicating disposition or discharge status of the member at the end service for the period covered on this claim. Refer to the UB-04 Billing Manual for more information.

Form Locators 18-28 — Condition Codes (required, if applicable)
Enter the code(s) identifying a condition related to this claim, if appropriate. Refer to the UB-04 Billing Manual for more information.

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. To indicate that Medicare Part A or Part B benefits were exhausted mid-stay, enter occurrence code "C3" and the date that Medicare benefits were exhausted. All dates must be printed in the MMDDYY format. Refer to the UB-04 Billing Manual for more information.

Form Locators 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
Enter the applicable value code and associated amount. Enter covered days using value code "80" and enter the number of covered days in the corresponding amount field using two decimal places. (For example, to indicate one day, providers would enter "1.00;" to indicate 12 days, providers would enter "12.00.") Enter noncovered days using value code "81" and enter the number of noncovered days in the amount field using two decimal places. Do not count the day of discharge for covered days. For noncovered days, enter the total noncovered days by the primary payer. The sum of covered days and noncovered days must equal the number of days in the "From-Through" period in Form Locator 6.

To indicate that Medicare Part A or Part B benefits were exhausted mid-stay, enter value code "AB" and the amount that Medicare allowed. Refer to the UB-04 Billing Manual for more information.

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 hospital publications or the UB-04 Billing Manual for information and codes.

Form Locator 43 — Description (not required)

Form Locator 44 — HCPCS/Rate/HIPPS Code (not required)

Form Locator 45 — Serv. Date (not required)

Form Locator 46 — Serv. Units
Enter the number of covered accommodation days or ancillary units of service for each line item. Do not count or include the day of discharge or death for accommodation codes.

Form Locator 47 — Total Charges (by Accommodation/Ancillary Code Category)
Enter the usual and customary charges pertaining to the related revenue code for the current billing period as entered in Form Locator 6.

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

Form Locator 49 — Unlabeled Field
Enter the "to" DOS in DD format only if the detail line includes a range of consecutive dates. The revenue code, procedure code and modifiers (if applicable), service units, and the charge must be 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 are required in this form locator for OCR processing. Any information populated by a provider's computer software is acceptable data for this form locator (e.g., "Same"). If computer software does not automatically complete this form locator, 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 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 —Principal Diagnosis Code and Present on Admission Indicator
Enter the valid, most specific *ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification)* 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). The principal diagnosis code selected must be the reason for admission. It should relate to one or more conditions or symptoms identified in the admission notes and/or admission work-up. Do not enter manifestation codes as the principal diagnosis; code the underlying disease first. The principal diagnosis may not include "E" (etiology) codes. "V" codes may be used as the principal diagnosis. The POA (present on admission) indicator is required for the primary diagnosis and must be included in the eighth digit of this field and be right justified. The diagnosis code must be left justified.

Form Locators 67A-Q — Other Diagnosis Codes and Present on Admission Indicator
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. The POA indicator is required for secondary diagnoses and must be included in the eighth digit of this field and be right justified. The diagnosis code must be left justified.

Form Locator 68 — Unlabeled Field (not required)

Form Locator 69 — Admit Dx
Enter a valid, most specific ICD-9-CM diagnosis code (up to five digits) provided at the time of admission as stated by the physician.

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 (required, if applicable)
Enter the valid ICD-9-CM surgical procedure code that identifies the principal procedure performed during the period covered by this claim and the date on which the principal procedure described on the claim was performed.

Note: Most often, the principal procedure will be that procedure which is most closely related to the principal discharge diagnosis.

Form Locator 74a-e — Other Procedure Code and Date (required, if applicable)
If more than six procedures are performed, report those that are most important for the episode using the same guidelines for determining principal procedure (Form Locator 74).

Form Locator 75 — Unlabeled Field (not required)

Form Locator 76 — Attending
Enter the attending provider's NPI.

Form Locator 77 — Operating (not required)

Form Locators 78 and 79 — Other Provider Name and Identifiers
If a referring provider is required on the claim, enter the referring provider's NPI, followed by "DN" in the qualifier field and the last and first names of the provider in the appropriate fields. If a rendering provider is required on the claim, enter the rendering provider's NPI, followed by "82" in the qualifier field and the last and first names of the provider in the appropriate fields.

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") insurance only, is enrolled in a Medicare Advantage Plan, or has no commercial health insurance, do not indicate an OI (other insurance) explanation code in Form Locator 80.

When the member has any other 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.

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

Medicare Advantage Plan and the claim should be processed as a crossover claim.

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 enrolled.

  Note: Home health agencies, medical equipment vendors, pharmacies, and physician services providers must be Medicare enrolled 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.

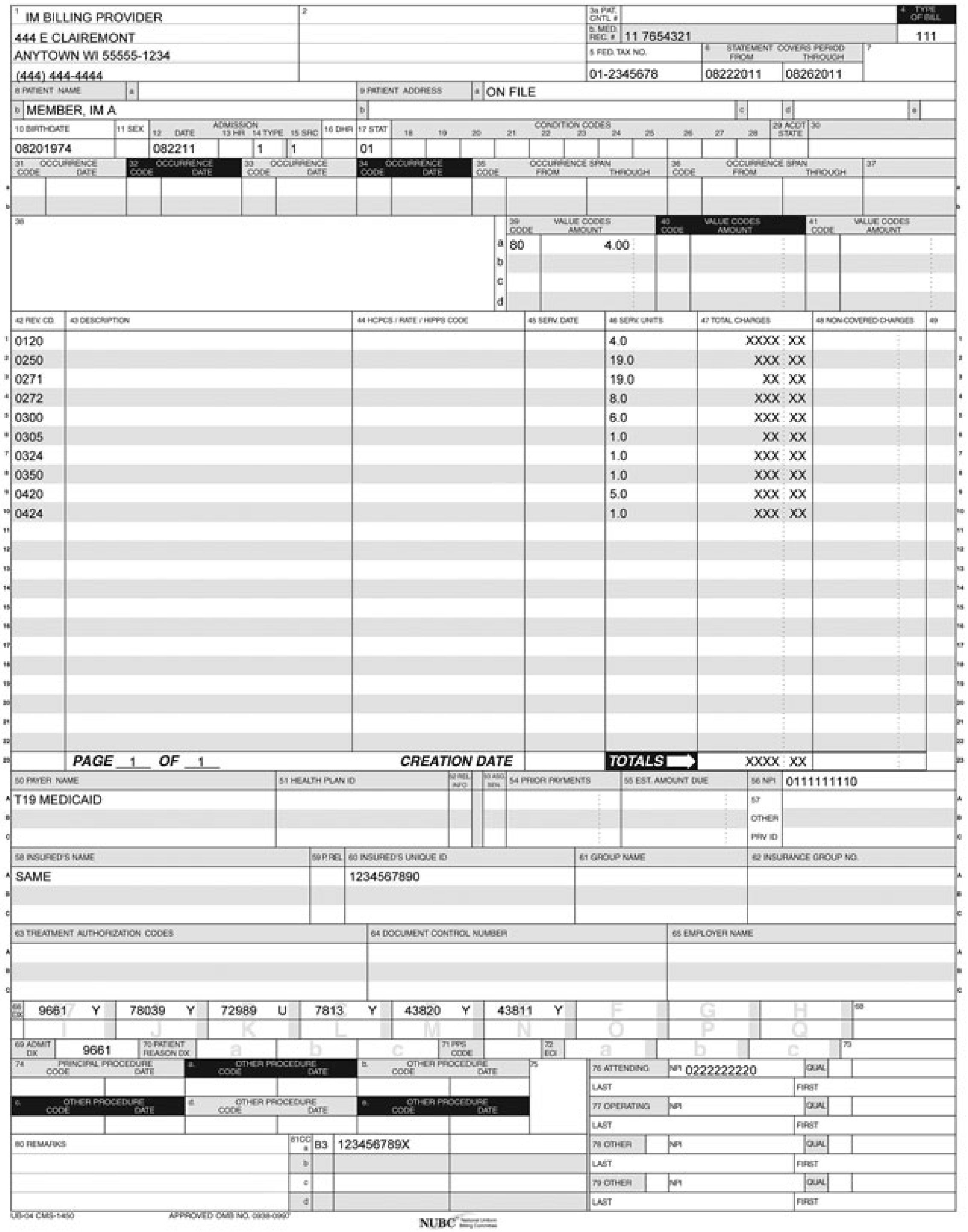
If none of the above is true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate.

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 enrolled in Medicare Part A. • The member is eligible for Medicare Part A. • The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or 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 enrolled in Medicare Part B. • The member is eligible for Medicare Part B. • The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or 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 enrolled in Medicare Part A. • The member is eligible for Medicare Part A. • The service is usually covered by Medicare Part A but not in this circumstance (e.g., member's diagnosis). *For Medicare Part B, use M-8 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as enrolled in Medicare Part B. • The member is eligible for Medicare Part B. • The service is usually covered by Medicare Part B but not in this circumstance (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 appropriate 10-digit provider taxonomy code on file with ForwardHealth in the second field.

Note: Providers should use qualifier "PXC" when submitting an electronic claim using the 837I (837 Health Care Claim: Institutional) transaction. For further instructions, refer to the companion guide for the 837I transaction.

Sample UB-04 Claim Form for Inpatient Hospital Services



1 IM BILLING PROVIDER
444 E CLAIREMONT
ANYTOWN WI 55555-1234
(444) 444-4444

3b MED. REC. # 11 7654321
4 TYPE OF BILL 111
5 FED. TAX NO. 01-2345678
6 STATEMENT COVERS PERIOD FROM 08222011 THROUGH 08262011
8 PATIENT NAME b MEMBER, IM A
9 PATIENT ADDRESS a ON FILE
10 BIRTHDATE 08201974
12 ADMISSION DATE 082211
14 TYPE 1
15 SRC 1
17 STAT 01
39 VALUE CODES a 80 4.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0120				4.0	XXXX XX	
0250				19.0	XXX XX	
0271				19.0	XX XX	
0272				8.0	XXX XX	
0300				6.0	XXX XX	
0305				1.0	XX XX	
0324				1.0	XXX XX	
0350				1.0	XXX XX	
0420				5.0	XXX XX	
0424				1.0	XXX XX	
	PAGE 1 OF 1	CREATION DATE		TOTALS	XXXX XX	

50 PAYER NAME A T19 MEDICAID
56 NPI 0111111110
58 INSURED'S NAME A SAME
60 INSURED'S UNIQUE ID 1234567890
67 9661 Y 78039 Y 72989 U 7813 Y 43820 Y 43811 Y
69 ADMIT DX 9661
76 ATTENDING NPI 0222222220
81CC a B3 123456789X

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

Topic #11677

Uploading Claim Attachments Via the Portal

Providers are able to upload attachments for most claims via the secure Provider area of the ForwardHealth Portal. This allows providers to submit all components for claims electronically.

Providers are able to upload attachments via the Portal when a claim is suspended and an attachment was indicated but not yet received. Providers are able to upload attachments for any suspended claim that was submitted electronically. Providers should note that all attachments for a suspended claim must be submitted within the same business day.

Claim Types

Providers will be able to upload attachments to claims via the Portal for the following claim types:

- Professional.
- Institutional.
- Dental.

The submission policy for compound and noncompound drug claims does not allow attachments.

Document Formats

Providers are able to upload documents in the following formats:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg).
- PDF (Portable Document Format) (.pdf).
- Rich Text Format (.rtf).
- Text File (.txt).

JPEG files must be stored with a ".jpg" or ".jpeg" extension; text files must be stored with a ".txt" extension; rich text format files must be stored with a ".rtf" extension; and PDF files must be stored with a ".pdf" extension.

Microsoft Word files (.doc) cannot be uploaded but can be saved and uploaded in Rich Text Format or Text File formats.

Uploading Claim Attachments

Claims Submitted by Direct Data Entry

When a provider submits a DDE (Direct Data Entry) claim and indicates an attachment will also be included, a feature button will appear and link to the DDE claim screen where attachments can be uploaded.

Providers are still required to indicate on the DDE claim that the claim will include an attachment via the "Attachments" panel.

Claims will suspend for 30 days before denying for not receiving the attachment.

Claims Submitted by Provider Electronic Software and 837 Health Care Claim Transactions

Providers submitting claims via 837 (837 Health Care Claim) transactions are required to indicate attachments via the PWK segment. Providers submitting claims via PES (Provider Electronic Solutions) software will be required to indicate attachments via the attachment control field. Once the claim has been submitted, providers will be able to search for the claim on the Portal and upload the attachment via the Portal. Refer to the Implementation Guides for how to use the PWK segment in 837 transactions and the PES Manual for how to use the attachment control field.

Claims will suspend with 30 days before denying for not receiving the attachment.

Timely Filing Appeals Requests

Topic #549

Requirements

When a claim or adjustment request meets one of the exceptions to the submission deadline, the provider is required to submit a Timely Filing Appeals Request (F-13047 (07/12)) form with a paper claim or an Adjustment/Reconsideration Request (F-13046 (07/12)) form to override the submission deadline.

DOS (dates of service) 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 and late DOS will be denied.

Topic #551

Resubmission

Decisions on Timely Filing Appeals Requests (F-13047 (07/12)) 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.

Topic #744

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 (F-13047 (07/12)) form for each claim and each adjustment to allow for electronic documentation of individual claims and adjustments submitted to ForwardHealth.
- 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 (place of service) code, etc., as effective for the DOS (date of service). 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 (F-13046 (07/12)) form. The most recent claim number (also known as the ICN (internal control number)) must be indicated on the Adjustment/Reconsideration Request form. This number may be the result of a ForwardHealth-initiated adjustment.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

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 (Department of Health Services).	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 submitted with the request.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

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 (Express Enrollment) for pregnant women or children identification card.
	  ○ White paper TE (Temporary Enrollment) for Family Planning Only Services identification card.
	  ○ The response received through Wisconsin's EVS (Enrollment Verification System) from a commercial eligibility vendor.
	  ○ The transaction log number received through WiCall.
		ForwardHealth
		Good Faith/Timely Filing
		Ste 50
		313 Blettner Blvd
		Madison WI 53784

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 (Remittance Advice) message. A copy of the RA message that shows the ForwardHealth-initiated adjustment must be submitted with the request.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

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 (general relief) 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 50 313 Blettner Blvd Madison WI 53784

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 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.	To receive consideration, the following must be submitted within 90 days of the Medicare processing date: • A copy of the Medicare remittance information. • The appropriate Medicare disclaimer code must be indicated on the claim.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

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	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

	remittance information. • A copy of the remittance information showing recoupment for crossover claims when Medicare is recouping payment.	

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 50 313 Blettner Blvd Madison WI 53784

Coordination of Benefits

2

Archive Date:01/02/2013

Coordination of Benefits:Commercial Health Insurance

Topic #595

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.

Topic #844

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 (prior authorization) before providing the service for covered services that require PA). If the requirements are followed, ForwardHealth may reimburse for the service up to the allowed amount (less any payments made by other health insurance sources).

Topic #598

Commercial Fee-for-Service

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

Topic #599

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 or Wisconsin Medicaid (i.e., state-contracted MCO (managed care organization), 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 and Wisconsin Medicaid 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.

Topic #601

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.

Topic #602

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.

Topic #596

Exhausting Commercial Health Insurance Sources

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

Step 1. Determine if the Member Has Commercial Health Insurance
If Wisconsin's EVS (Enrollment Verification System) does not indicate that the member has commercial health insurance, the provider may submit a claim to ForwardHealth unless the provider is otherwise aware of commercial health insurance coverage. **If the member disputes the information as it is indicated in the EVS,** the provider should submit a completed Other Coverage Discrepancy Report (F-1159 (10/08)) 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 Medicaid-allowed amount. If billing commercial health insurance first, the provider should proceed to Step 3. • The provider may submit a claim without indicating an other insurance indicator on the claim. The provider may not bill ForwardHealth and commercial health insurance simultaneously. Simultaneous billing may constitute fraud and interferes with ForwardHealth'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 ForwardHealth and the member, the provider is required to return the lesser amount to ForwardHealth.
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.

Topic #263

Members Unable to Obtain Services Under Managed Care Plan

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

- Children enrolled in a commercial managed care plan by a noncustodial parent if the custodial parent refuses to use the coverage.
- Members enrolled in a commercial managed care plan who reside outside the service area of the managed care plan.

- Members enrolled in a commercial managed care plan who enter a nursing facility that limits the member's access to managed care providers.

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

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

- Indicate "OI-Y" on paper claims.
- Refer to the Wisconsin PES (Provider Electronic Solutions) Manual or the appropriate 837 (837 Health Care Claim) companion guide to determine the appropriate other insurance indicator for electronic claims.

Topic #604

Non-Reimbursable Commercial 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.

Topic #605

Other Insurance Indicators

Other insurance indicators are used to report results of commercial health insurance billing and to report when existing insurance was not billed. Providers are required to use these indicators as applicable on professional, institutional, or dental 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 (Enrollment Verification System) indicates no commercial health insurance for the DOS (date of service).
- The service does not require other health insurance billing.
- Claim denials from other payers relating to NPI (National Provider Identifier) and related data should be resolved with that payer and not submitted to ForwardHealth. Payments made in these situations may be recouped.

Documentation Requirements

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

Topic #603

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.
- CCS (Comprehensive Community Services).
- Crisis Intervention services.
- CRS (Community Recovery Services).
- CSP (Community Support Program) services.
- Family planning services.
- PNCC (prenatal care coordination) services.
- Preventive pediatric services.
- SMV (specialized medical vehicle) services.

Topic #769

Services Requiring Commercial Health Insurance Billing

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

- Ambulance services, if provided as emergency services.
- Anesthetist services.
- Audiology services, unless provided in a nursing home or SNF (skilled nursing facility).
- Blood bank services.
- Chiropractic services.
- Dental services.
- DME (durable medical equipment) (rental or purchase), prosthetics, and hearing aids if the billed amount is over $10.00 per item.
- Home health services (excluding PC (personal care) services).
- Hospice services.
- Hospital services, including inpatient or outpatient.
- Independent nurse, nurse practitioner, or nurse midwife services.
- Laboratory services.
- Medicare-covered services for members who have Medicare and commercial health insurance.
- Mental health/substance abuse services, including services delivered by providers other than physicians, regardless of POS (place of service).
- PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services, unless provided in a nursing home or SNF.
- Physician assistant services.
- Physician services, including surgery, surgical assistance, anesthesiology, or any service to a hospital inpatient. However, physician services provided to a woman whose primary diagnosis indicates a high-risk pregnancy do not require commercial health insurance billing.
- Pharmacy services for members with verified drug coverage.
- Podiatry services.
- PDN (private duty nursing) services.
- Radiology services.

- RHC (rural health clinic) services.
- Skilled nursing home care, if any DOS (date of service) is within 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 ForwardHealth indicates the member has other vision coverage, the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- Ophthalmology services.
- Optometrist services.

If ForwardHealth indicates the member has Medicare Supplemental Plan Coverage, the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

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

ForwardHealth has identified services requiring Medicare billing.

Medicare

Topic #664

Acceptance of Assignment

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

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

Topic #666

Claims Denied for Errors

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

Topic #668

Claims Processed by Commercial 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.

Topic #670

Claims That Do Not Require Medicare Billing

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

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

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

Topic #704

Claims That Fail to Cross Over

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

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

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

If automatic crossover claims do not appear on the 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 and the ZIP+4 code of the practice location on file with ForwardHealth are required when additional data is needed to identify the provider.

Topic #667

Claims for Services Denied by Medicare

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

Topic #671

Crossover Claims

A Medicare crossover claim is a Medicare-allowed claim for a dual eligible or QMB-Only (Qualified Medicare Beneficiary-Only) member sent to ForwardHealth for payment of coinsurance, 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 (durable medical equipment) 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 (Coordination of Benefits Contractor).

Claims will be forwarded if the following occur:

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

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 (Remittance Advice) 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 or Wisconsin Medicaid at the time the service was submitted to Medicare for payment, but the member was retroactively determined enrolled in BadgerCare Plus or Medicaid.
- The claim is for a member who is enrolled in a Medicare Advantage Plan.

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

- The NPI (National Provider Identifier) that ForwardHealth has on file for the provider.
- The taxonomy code that ForwardHealth has on file for the provider.
- The ZIP+4 code that corresponds to the practice location address on file with ForwardHealth.

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

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

Topic #672

Definition of Medicare

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

Medicare coverage is divided into four parts:

- Part A (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 (physical therapy) services, OT (occupational therapy) services, and some home health services).
- Part C (i.e., Medicare Advantage).
- Part D (i.e., drug benefit).

Topic #684

Dual Eligibles

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

Dual eligibles may receive coverage for the following:

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

Topic #1421

Dual-Eligibility During Inpatient Stay

If a member becomes eligible for both Medicare and Wisconsin Medicaid during an inpatient stay, submit the claim to Medicare first.

Use the following billing instructions for dual-eligibles whose Medicare Part A benefits are exhausted prior to or during an inpatient hospital stay.

Part A Benefits Exhausted Prior to Admission (No Part A)

- Bill Medicare for all Medicare Part B billable ancillaries for the noncovered Medicare Part A days. Wisconsin Medicaid allows and pays the coinsurance and any deductible on those Medicare-approved services through the outpatient crossover claim.
- Bill Wisconsin Medicaid for all inpatient charges including the Medicare Part B charges.
    - In Form Locators 39-41 a-d of the UB-04 Claim Form, use the value code "AB" and state the total Medicare allowed amount for Medicare Part B services (not the Medicare payment amount).
    - In Form Locator 80 of the UB-04 Claim Form, indicate Medicare disclaimer code "M-7." Wisconsin Medicaid pays the straight Wisconsin Medicaid inpatient claim deducting the amount shown with value code AB from the DRG reimbursement since this amount was already paid through the outpatient crossover claim.
    - Do not attach the Medicare RA (Remittance Advice) to this claim.
- Bill Medicare for the Professional Component charges on the 1500 Health Insurance Claim Form. Wisconsin Medicaid allows and pays the coinsurance and any deductible on those Medicare-approved services through the professional crossover claim.

Part A Benefits Exhausted Mid-Stay (Partial Part A)

- Bill Medicare for all charges for the entire stay. Medicare approves and pays the Medicare Part A covered days. Wisconsin Medicaid allows and pays the coinsurance and any deductible on those Medicare-approved days through the inpatient crossover claim.
- Bill Medicare for all Medicare Part B billable ancillaries for the noncovered Medicare Part A days. Wisconsin Medicaid allows and pays the coinsurance and any deductible on those Medicare-approved services through the outpatient crossover claim.
- Bill Wisconsin Medicaid for all inpatient charges for the entire stay, including the Medicare Part B charges.
    - In Form Locators 39-41 a-d of the UB-04 Claim Form, use value code "AB" to indicate the Medicare paid amount for both Medicare Part A and Medicare Part B services. Wisconsin Medicaid pays the straight Wisconsin Medicaid inpatient claim deducting the total amounts shown with value code AB from the DRG reimbursement since these amounts were already paid through the outpatient and inpatient crossover claims.
    - In Form Locators 31-34 of the UB-04 Claim Form, indicate occurrence code "C3" and the date that Medicare Part A benefits were exhausted.
    - In Form Locator 80 of the UB-04 Claim Form, indicate Medicare disclaimer code "M-7."
- Do not attach the Medicare RA to this claim.

Topic #669

Exhausting Medicare Coverage

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

Adjustment Request for Crossover Claim
The provider may submit a paper or electronic adjustment request. If submitting a paper Adjustment/Reconsideration Request (F-13046 (07/12)) 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 (Medicare Managed Care)" 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 (F-13047 (07/12)) 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 or Wisconsin Medicaid, the provider may proceed as follows:

- Bill commercial health insurance, if applicable.
- Submit a claim to ForwardHealth using the appropriate Medicare disclaimer code. If applicable, the provider should indicate the appropriate other insurance indicator. 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 ForwardHealth's procedures for submitting crossover claims.

Topic #687

Medicare Advantage

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

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 (Explanation of Medicare Benefits). 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.

Topic #688

Medicare Disclaimer Codes

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

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

When submitting a claim for a covered service that was denied by Medicare, providers should resubmit the claim *directly* to ForwardHealth using the appropriate Medicare disclaimer code.

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.

Topic #689

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(7), 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 A 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 Medicaid-enrolled provider who is enrolled in Medicare.

Services for Qualified Medicare Beneficiary-Only Members

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

Medicaid-enrolled provider who is enrolled in Medicare.

Topic #8457

Medicare Late Fees

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

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

Resubmitting Medicare Crossover Claims with Late Fees

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

Paper Claim Submissions

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

Electronic Claim Submissions

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

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

- Billed Amount: $110.00.
- Allowed Amount: $100.00.
- Coinsurance: $20.00.
- Late Fee: $5.00.
- Paid Amount: $75.00.

Since ForwardHealth considers the late fee part of the paid amount, providers should add the late fee to the paid amount reported on the Medicare remittance. In the example above, add the late fee of $5.00 to the paid amount of $75.00 for a total of $80.00. The claim should report the Medicare paid amount as $80.00.

Topic #690

Medicare Retroactive Eligibility

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

retroactive period. The provider is required to then bill Medicare for the services and follow ForwardHealth's procedures for submitting crossover claims. Claims found to be in conflict with this program requirement will be recouped.

Topic #692

Qualified Medicare Beneficiary-Only Members

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

- Medicare monthly premiums for Part A, Part B, or both.
- Coinsurance, 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.

Topic #686

Reimbursement for Crossover Claims

Professional Crossover Claims

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

Total payment for a Medicare Part B-covered service (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-covered 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 three examples of how the limitations are applied.

Reimbursement for Coinsurance or Copayment of Medicare Part B-Covered Services			
Explanation	**Example**		
	1	**2**	**3**
Provider's billed amount	$120	$120	$120
Medicare-allowed amount	$100	$100	$100
Medicaid-allowed amount (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 (dates of service) 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.

Inpatient Hospital Services

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

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

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

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

Reimbursement for Medicare Part A-Covered Inpatient Hospital Services Provided To Dual Eligibles			
Explanation	**Example**		
	1	**2**	**3**
Provider's billed amount	$1,200	$1,200	$1,200
Medicare-allowed amount	$1,000	$1,000	$1,000
Medicaid-allowed amount (e.g., diagnosis-related group or per diem)	$1,200	$750	$750
Medicare-paid amount	$1,000	$800	$500
Difference between Medicaid-allowed amount and Medicare-paid amount	$200	($-50)	$250
Medicare coinsurance, copayment and deductible	$0	$200	$500
Medicaid payment	$0	$0	$250

Topic #770

Services Requiring Medicare Billing

If Wisconsin's EVS (Enrollment Verification System) indicates Medicare + Choice, the provider is required to bill the following services to the Medicare Advantage Plan before submitting claims to ForwardHealth:

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

If the EVS indicates Medicare Cost, 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.

Topic #1419

Swing-Bed Services

Rural hospitals with fewer than 100 beds can receive approval from the CMS (Centers for Medicare and Medicaid Services) for beds to be used interchangeably as hospital and skilled nursing facility beds. If hospital beds are used as skilled nursing facility beds, the services provided to the members in the beds are considered swing-bed services.

Swing-bed claims are covered only for dual-eligibles. These claims automatically cross over to Wisconsin Medicaid from Medicare.

Wisconsin Medicaid pays only the coinsurance and deductible amount on Medicare crossover claims for swing-bed services and does not pay swing-bed services that Medicare denies. Swing-bed services are not paid on Medicaid-only claims because they are not a covered service.

Other Coverage Information

Topic #4940

After Reporting Discrepancies

After receiving an Other Coverage Discrepancy Report (F-1159 (10/08)), ForwardHealth confirms the information and updates the member files.

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

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

Topic #4941

Coverage Discrepancies

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

Topic #609

Insurance Disclosure Program

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

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

Topic #610

Maintaining Accurate and Current Records

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

- Insurance Disclosure program.
- Providers who submit an Other Coverage Discrepancy Report (F-1159 (10/08)) form.
- Member certifying agencies.

- Members.

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

Topic #4942

Reporting Discrepancies

Providers are encouraged to report discrepancies to ForwardHealth by submitting the Other Coverage Discrepancy Report (F-1159 (10/08)) form. Providers are asked to complete the form in the following situations:

- The provider is aware of other coverage information that is not indicated by Wisconsin's EVS (Enrollment Verification System).
- The provider received other coverage information that contradicts the information indicated by the EVS.
- A claim is denied because the EVS indicates commercial managed care coverage but the coverage is not available to the member (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 (managed care organization).

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

Provider-Based Billing

Topic #660

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 or Wisconsin Medicaid. For example, a provider-based billing claim is created when BadgerCare Plus or Wisconsin Medicaid pays a claim and later discovers that other coverage exists or was made retroactive. Since BadgerCare Plus and Wisconsin Medicaid 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.

Topic #658

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.

Topic #661

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.

Topic #659

Responding to ForwardHealth After 120 Days

If a response is not received within 120 days, the amount originally paid by BadgerCare Plus or Wisconsin Medicaid 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 (dates of service) 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 (Wisconsin's Enrollment Verification System) 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 313 Blettner Blvd Madison WI 53784
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 (F-1159 (10/08)) 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 313 Blettner Blvd Madison WI 53784
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 313 Blettner Blvd Madison WI 53784
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 313 Blettner Blvd Madison WI 53784
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 313 Blettner Blvd Madison WI 53784

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 (F-13047 (07/12)) form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The provider discovers that the	• An Other Coverage Discrepancy Report form.	Send the Other Coverage

member's other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	• *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.	Discrepancy Report form to the address indicated on the form. Send the timely filing appeals request to the following address: ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
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 50 313 Blettner Blvd Madison WI 53784
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: ○ 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.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The commercial health insurance carrier does not respond to an initial and follow-up provider-based	• A claim (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator.	ForwardHealth Timely Filing Ste 50

billing claim.	• A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	313 Blettner Blvd Madison WI 53784

Topic #662

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 (Enrollment Verification System) 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. • The DOS (date of service), 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	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567

	form.	

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

Topic #663

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

Topic #657

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 and Wisconsin Medicaid will not reimburse providers if they receive payment from either of these sources.

The provider may choose a different option for each DOS (date of service). 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.

Topic #829

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 or Wisconsin Medicaid, 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.

Topic #826

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.

Topic #827

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

3

Archive Date:01/02/2013

Covered and Noncovered Services:Codes

Topic #830

Diagnosis Codes

All diagnosis codes indicated on claims (and PA (prior authorization) requests when applicable) must be the most specific ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) 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.

Topic #1418

Revenue Codes

The following is a complete list of Medicaid-allowable revenue codes for inpatient and outpatient hospital claims.

Note: Providers are required to enter revenue codes for accommodation and ancillary services in Form Locator 42 of the UB-04 Claim Form.

Policy	Specific Revenue Codes
Revenue codes that require a service-specific third digit from the UB-04 Billing Manual	011X, 012X, 013X, 015X, 016X, 017X, 020X, 021X, 025X, 036X, 051X, 071X, 090X, 091X, 092X, 094X, 096X
Revenue codes that require a CPT (Current Procedural Terminology) laboratory procedure code for outpatient services	030X, 031X, 0923, 0925
Revenue codes for dental services	0512 (Use when providing dental services as part of an outpatient visit.)
Revenue codes for vision care services	0519 (Use when providing vision care services as part of an outpatient visit.)
Outpatient observation room	0710 (Use when member is under observation after recovering from ambulatory surgery.)
Revenue codes exempt from member copayment	0820-0859, 0901, 0918 *Note:* Revenue code 0253 is exempt from member copayment on crossover claims. Revenue code 0450 is exempt from copayment for outpatient services.
Noncovered revenue codes	0140-0149, 0180-0189, 0220-0221, 0229, 0294, 0374, 0547-0548, 0550, 0609, 0624, 0637, 0660-0669, 0670-0679, 0780-0788, 0880, 0990-0999
Noncovered revenue codes	0599, 0709, 0719, 0749, 0759, 0779, 0789, 0799

"Reserved for Future Assignment"	
Noncovered revenue codes for psychiatric hospitals	0520, 0529, 0940, 0949
Noncovered revenue codes for general hospitals billing psychiatric or substance abuse services	0520, 0529, 0940, 0949
Nonbillable revenue codes	*Nonbillable for bill type 011X:* 0100-0101, 0115, 0135, 0155, 0240, 0249, 0253, 0259, 0279, 0291-0293, 0299, 0479, 0530-0531, 0539, 0540-0546, 0549, 0551-0552, 0559, 0570-0572, 0579, 0580-0582, 0589, 0590, 0600-0604, 0650-0657, 0659, 0912-0913, 0960-0964, 0969, 0971-0979, 0981-0989 *Nonbillable for bill type 013X:* 0180-0239, 0240, 0249, 0259, 0279, 0299, 0540-0546, 0549, 0550-0552, 0559, 0570-0572, 0579, 0580-0582, 0589, 0590, 0600-0604, 0650-0657, 0659, 0912-0913, 0990-0999
Billable, noncovered revenue code	0180
Restricted revenue codes	0110-0114, 0116-0117, 0119
Revenue code for medication checks	0510

Topic #643

Unlisted Procedure Codes

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

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

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

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

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

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

Certain unlisted procedure codes require PA. Providers should follow their service-specific PA instructions and documentation

requirements for requesting PA. For a list of procedure codes for which ForwardHealth requires PA, refer to the service-specific interactive maximum allowable fee schedules.

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

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

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

Unlisted Codes That Do Not Require Prior Authorization

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

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

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

How to Submit Claims and Related Documentation

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

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

Covered Services and Requirements

Topic #1398

A Comprehensive Overview

Inpatient Services Requirements

Inpatient services must meet all the following criteria:

- The care is directed by a physician or dentist.
- The member meets the criteria for inpatient status.
- The services are medically necessary.

Topic #9517

Authorization for Basic Plan Hospital Services

Hospitals are strongly recommended to obtain authorization for services. Reimbursement for services without authorization is not guaranteed by ForwardHealth. Authorization is obtained via a new ForwardHealth Portal feature or by calling Provider Services. Providers should have the following information on hand when they call to obtain authorization:

- The provider's NPI (National Provider Identifier).
- The type of hospital service (either inpatient or outpatient).
- The member's full name, date of birth, and/or ForwardHealth identification number.
- The date of admittance to the inpatient hospital.
- The "from" DOS (date of service). This is the first DOS that a provider would enter on Form Locator 6 (Statement Covers Period [From -Through]) of the UB-04 claim form.

Topic #9439

Basic Plan Covered Services

Members enrolled in the BadgerCare Plus Basic Plan are covered for an initial inpatient hospital stay per enrollment year, prior to application of the member's $7,500.00 hospital deductible. Inpatient hospitals are strongly recommended to obtain authorization for services. A hospital stay in an acute care hospital or an IMD (Institute of Mental Disease) when the member has a discharge diagnosis of either mental illness or substance abuse is not covered by the Basic Plan.

Topic #9317

Basic Plan Enrollment Year

The BadgerCare Plus Basic Plan enrollment year is the time period used to determine service limitations for members in the Basic Plan.

The Basic Plan enrollment year is defined as the continuous 12-month period beginning on the first day of enrollment (the first day

of the month) in the Basic Plan and ending on the last day of the 12th full calendar month.

When a member exceeds his or her service limitations, the service is considered noncovered and the member is responsible for payment of the service.

Topic #4337

Benchmark Plan Covered Inpatient Hospital Services

All inpatient hospital services covered under the BadgerCare Plus Benchmark Plan are the same as those covered under the BadgerCare Plus Standard Plan.

Topic #5497

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 (Department of Health Services) 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.

Topic #4339

Benchmark Plan Service Limitations for Mental Health and Substance Abuse

There are no service limitations under the BadgerCare Plus Benchmark Plan for mental health and substance abuse services.

Topic #1568

Care Must Be Physician or Dentist Directed

The care and treatment of hospital inpatients are required to be under the direction of a physician or dentist in an institution enrolled under DHS 105.07 or DHS 105.21, Wis. Admin. Code.

Topic #8278

Continuous Stay Policy for Hospital Services That Span More Than One Date of Service

Wisconsin Medicaid and BadgerCare Plus consider all hospital services to be part of a single, continuous inpatient stay when both of the following occur:

- The member is eventually admitted as an inpatient.
- The stay takes place over two or more DOS (dates of service).

Providers are required to include on an inpatient claim all services provided during an outpatient visit that span through midnight and which eventually continue to admission of the member for an inpatient stay. That is, outpatient services provided on the date directly prior to the date on which the member is counted in the midnight census are charged in the inpatient claim.

Topic #5357

Core Plan Covered Services

Inpatient hospital services covered under the BadgerCare Plus Core Plan are the same as those covered under the BadgerCare Plus Standard Plan, with one exception. A hospital stay in an acute care hospital or an IMD (Institute for Mental Disease) when the member has a discharge diagnosis of either mental illness or substance abuse is not covered by the Core Plan.

Topic #5317

Core Plan Enrollment Year

The BadgerCare Plus Core Plan enrollment year is the time period used to determine service limitations for members in the Core Plan. Services received while covered under the BadgerCare Plus Standard Plan or the BadgerCare Plus Benchmark Plan do not count toward the enrollment year service limitations in the Core Plan and vice versa.

The Core Plan enrollment year is defined as the continuous 12-month period beginning on the first day of enrollment (either the first or the 15th day of the month) in the Core Plan and ending on the last day of the 12th full calendar month.

The Core Plan enrollment year will reset if there is a gap in coverage for more than a full calendar month. For example, a member's situation changes for a few months and the member is temporarily ineligible for the Core Plan. More than one month later, the member becomes eligible again and re-applies for the Core Plan. When the member's application is approved and Core Plan coverage begins, the Core Plan enrollment year resets. Core Plan service limitations for this member also reset.

When a member exceeds his or her service limitations, the service is considered noncovered and the member is responsible for payment of the service.

Enrollment Year for Members Switching Between the Core Plan and the Benchmark Plan

Special conditions apply to the enrollment year for members who switch between the Core Plan and the Benchmark Plan.

If a member is in the Core Plan and subsequently becomes eligible for and enrolls in the Benchmark Plan, his or her enrollment year in the Core Plan automatically ends. A new enrollment year under the Core Plan will begin if the member re-enrolls in the Core Plan at a later date.

If a member is in the Benchmark Plan, becomes temporarily eligible for and enrolls in the Core Plan, then switches back into the Benchmark Plan, the enrollment year for the Benchmark Plan will reset if there has been a gap in coverage for more than one full calendar month. If there has not been a gap in coverage for more than one full calendar month, and if the date of re-enrollment in the Benchmark Plan is within the initially established enrollment year dates, the Benchmark Plan enrollment year will not reset.

For example, a member is enrolled in the Benchmark Plan as of July 1, 2009. That member's Benchmark Plan enrollment year is defined as July 1, 2009, through June 30, 2010. The member loses her eligibility for the Benchmark Plan as of September 30, 2009. The member applies for the Core Plan and her enrollment begins on October 15, 2009. (The gap in coverage for this member is less than one full calendar month.) The member becomes ineligible for the Core Plan and the member's enrollment ends on March 31, 2010. The member re-enrolls in the Benchmark Plan, effective April 1, 2010. (The date of re-enrollment in the Benchmark Plan is within the dates of the previous Benchmark Plan enrollment year.) The member's enrollment year under the Benchmark Plan does not reset and is still defined as July 1, 2009 through June 30, 2010.

Topic #44

Definition of Covered Services

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

Topic #85

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 (prior authorization) or other program requirements may be waived in emergency situations.
- Non-enrolled in-state providers may be reimbursed for emergency services.
- Non-U.S. citizens may be eligible for covered services in emergency situations.

Topic #9657

Emergency Room Covered and Noncovered Services Under the Basic Plan

Members enrolled in the BadgerCare Plus Basic Plan are covered for two emergency room visits per enrollment year. After two visits, the benefit is considered exhausted and any subsequent emergency room visits are not covered.

Providers may bill the member the hospital's usual and customary charge for noncovered emergency room visits.

Emergency room visits do not count toward the member's deductible.

Claims for physician services associated with emergency room visits may be submitted to ForwardHealth separately for reimbursement from an emergency room visit claim.

Topic #5377

Enrollment or Disenrollment Between BadgerCare Plus Plans During a Hospital Stay

Providers are required to follow the policies, procedures, and cost sharing of the plan the member was enrolled in on the first day of the hospitalization admittance even if the member changes plans mid-stay.

For example, a member enrolled in the BadgerCare Plus Core Plan is admitted to the hospital on March 30, 2009. The member switches from the Core Plan to the BadgerCare Plus Standard Plan (or the BadgerCare Plus Benchmark Plan) as of April 1, 2009, and is discharged from the hospital on April 3, 2009. The provider should follow the policies and procedures for hospitalization under the Core Plan for the entire hospitalization. The member is responsible for copayments under the Core Plan.

Hospitalization in this section is defined as an inpatient stay at a Medicaid-enrolled hospital as defined in DHS 101.03(76), Wis. Admin. Code. Discharge from one hospital and admission to another within 24 hours for continued treatment shall not be considered a discharge under this section. Discharge is defined here as it is in the UB-04 Manual.

Topic #9477

Hospital Transfers Treated as One Continuous Stay Under the Basic Plan

ForwardHealth will consider transfers from one hospital to another as one continuous inpatient stay. Each hospital is required to obtain authorization before treating the member. When obtaining authorization, providers should indicate that the authorization is for a transfer.

Note: All hospitals will be reimbursed for their portion of the continuous stay.

Topic #1397

Inappropriate Inpatient Admissions

Payment for inpatient care that could have been performed on an outpatient basis may not exceed the facility's outpatient rate-per-

visit paid. If a payment has been made, Wisconsin Medicaid recovers the difference between the payment and the outpatient rate-per-visit.

Inappropriate Discharge and Readmission

If the ERO (External Review Organization) determines that it was medically inappropriate for a patient to have been discharged from a hospital and as a result, that patient needed to be readmitted to a hospital, Wisconsin Medicaid will not issue a payment for the first discharge. Wisconsin Medicaid will recoup any payment made under these circumstances.

Admission for Observation Purposes

In some cases, an outpatient member may be admitted for observation for a portion of the day. Because the member is not admitted as an inpatient and counted in the midnight census, he or she is not an inpatient.

Emergency Room Services

Emergency room services are considered to be outpatient services unless the member is admitted to the hospital and counted in the midnight census.

Topic #1395

Inpatient Status

A member is considered an inpatient when the member is admitted to the hospital as an inpatient and is counted in the midnight census. In situations when a member inpatient admission occurs and the member dies, is discharged following an obstetrical stay, or is transferred to another facility on the day of admission, the member is also considered an inpatient of the hospital.

Under DHS 107.08(3)(c)4, Wis. Admin. Code, Wisconsin Medicaid does not reimburse outpatient claims for services provided to an inpatient in another hospital, except on the date of admission or the date of discharge. For any other day during the inpatient stay, the hospital providing the outpatient services must arrange payment with the inpatient hospital.

Topic #1357

Inpatient and Outpatient Services for Same Date of Service

In accordance with DHS 107.08(4)(a)4, Wis. Admin. Code, if inpatient and outpatient services are provided for the same member, at the same hospital, on the same DOS (date of service) as the date of the inpatient hospital admission or discharge, the outpatient services are not separately reimbursed and must be included on the inpatient claim. This does not include reference laboratory services. Include outpatient claims for the hospital on the same date of admission or date of discharge on the inpatient claim.

Topic #1411

Institution for Mental Disease Services

Certification of Need Requirements

Federal and state regulations require providers to conduct and document a CON (Certification of Need) assessment for all members under the age of 21 who are admitted to a psychiatric or substance abuse IMD (Institution for Mental Disease) for elective/urgent or emergency psychiatric or substance abuse treatment services.

Elective Urgent Admissions

Providers are required to complete and document an elective/urgent CON assessment prior to all elective/urgent admissions for all members under the age of 21. Providers may use the reproducible Certification of Need for Elective/Urgent Psychiatric Substance Abuse Admissions to Hospital Institutions for Mental Disease for Members Under Age 21 (F-11047 (02/09)) form and completion instructions. Maintain completed forms in members' medical records.

As specified in 42 CFR Part 441.153, elective/urgent admissions require an independent team to complete the elective/urgent CON assessment. This independent team is required to meet the following requirements:

- The team is required to consist of at least two individuals, one of whom is a physician.
- The team members are required to have competence in the diagnosis and treatment of mental illness, preferably in child psychiatry.
- The individuals are required to have knowledge of the member's situation.

None of the members of the independent team may have an employment or consultant relationship with the admitting facility. A referring or admitting physician may be a part of the independent team if he or she does not have an employment or consultant relationship with the admitting facility and meets the independent team requirements listed above. Each team member is required to sign and date the elective/urgent CON form and state his or her credentials.

Emergency Admissions

Emergency admissions are admissions necessary to prevent death or serious impairment of the member's health. The hospital is responsible for ensuring that there is clinical documentation to justify an emergency admission.

Providers are required to complete and document an emergency CON assessment within 14 days of admission for emergency admissions for members under 21 years of age. Providers may use the reproducible Certification of Need for Emergency Psychiatric/Substance Abuse Admissions to Hospital Institutions for Mental Disease for Members Under Age 21 and in Cases of Medicaid Determination After Admission (F-11048 (02/09)) form and completion instructions. Maintain completed forms in members' medical records.

As specified in 42 CFR 441.153, the hospital's interdisciplinary team (which is described in 42 CFR 441.156) is responsible for performing the emergency CON assessment and completing the emergency CON form. This team is required to include, at a minimum, one of the following:

- A board-eligible or board-certified psychiatrist.
- A clinical psychologist who has a Doctoral degree and a physician licensed to practice medicine or osteopathy.
- A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a Master's degree in clinical psychology or who is certified by the DSL (Division of Supportive Living) DHS (Department of Health Services) as meeting the requirements for health insurance reimbursement.

The team is also required to include at least one of the following individuals:

- An occupational therapist who is licensed by the Wisconsin DSPS (Department of Safety and Professional Services) and who has specialized training or one year of experience in treating mentally ill individuals.
- A psychiatric social worker.
- A psychologist who has a Master's degree in clinical psychology or is certified by the DSL.

- A registered nurse with specialized training or one year of experience in treating mentally ill individuals.

Each member is required to sign and date the emergency CON form and state his or her credentials.

Documentation Requirements for Certification of Need Assessments

Providers may use reproducible CON forms or they may use their own, equivalent forms. Wisconsin Medicaid requires that providers equivalent versions of the forms provide all the information that is included in Wisconsin Medicaid's versions of the CON forms. Hospitals are required to keep the CON form in the member's medical record according to the requirements for retention of records in DHS 106.02(9)(b), Wis. Admin. Code.

The CON assessment and CON form are part of the retrospective review performed by the ERO (External Review Organization). These reviews include an evaluation of the CON document, which must be included in the medical record of all members under the age of 21 admitted to an IMD (institution for mental disease) hospital. When the ERO requests the IMD record and the CON form is either absent or not completed correctly, a technical denial letter is issued to the IMD. The technical denial letter allows the provider 20 calendar days to submit additional information.

Once the ERO has received the corrected form or missing information, the ERO completes its review of the CON compliance. Certification of Need review outcomes are reported to the DHS on a semiannual basis. Failure to perform the CON assessment and/or properly complete the CON form will result in denied claims payment or recoveries of payments made.

Enrollment After Admission

If a member becomes eligible for Wisconsin Medicaid after admission or is made retroactively eligible after discharge, the hospital's interdisciplinary team is required to complete an emergency Certification of Need assessment and the Certification of Need for Emergency Psychiatric/Substance Abuse Admissions to Hospital Institutions for Mental Disease for Members Under Age 21 and in Cases of Medicaid Determination After Admission form. For an individual applying for Medicaid while still in the facility, 42 CFR 441.153 requires that the certification must be made by the interdisciplinary team responsible for the plan of care and it must include any period of time before application for which claims are made. Providers may use the reproducible Certification of Need for Emergency Psychiatric/Substance Abuse Admissions to Hospital Institutions for Mental Disease for Members Under Age 21 and in Cases of Medicaid Determination After Admission form and completion instructions.

Transfers to Institutions for Mental Disease

Wisconsin Medicaid requires a CON assessment and CON form for all patient transfers when the receiving hospital is a psychiatric or substance abuse IMD. This applies even if the transferring hospital is an IMD and a CON assessment was previously completed. Providers are required to follow these procedures for elective/urgent and emergency admissions.

Topic #84

Medical Necessity

Wisconsin Medicaid reimburses only for services that are medically necessary as defined under DHS 101.03(96m), Wis. Admin. Code. Wisconsin Medicaid may deny or recoup payment if a service fails to meet Medicaid medical necessity requirements.

Topic #86

Member Payment for Covered Services

Under state and federal laws, a Medicaid-enrolled 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 ForwardHealth does not necessarily render a member liable. However, a covered service for which PA (prior authorization) 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 enrollment.

Topic #9777

Physician Office Visits Under the Basic Plan

The Basic Plan reimburses providers for 10 office visits per enrollment year. Certain procedure codes count toward the 10-visit limit. If a physician treats the member during an inpatient hospital stay or during an outpatient hospital visit and the physician submits a claim for that member, the physician services billed will not count toward the 10-office visit limit.

Topic #66

Program Requirements

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

Topic #9457

Rehabilitation Hospital Stays (Non-psychiatric) Covered Under the Basic Plan

The member's initial stay in a non-psychiatric rehabilitation hospital may count toward the initial covered inpatient hospital stay per enrollment year prior to application of the member's deductible. ForwardHealth will reimburse the provider for up to 14 days (for one continuous stay). This is considered reimbursement in full and the member must not be billed for additional days. After the first visit, inpatient non-psychiatric rehabilitation hospital stays count toward the member's $7,500.00 deductible. During this time, hospital providers may not bill the member for more than 14 times the per diem for the entire length of the stay. Rehabilitation stays after the deductible is met are also paid a maximum of 14 times the per diem for the entire length of the stay, with no additional liability accruing to the member.

Rehabilitation hospitals are strongly recommended to obtain authorization before providing services. Reimbursement for services without authorization is not guaranteed by ForwardHealth.

Note: Inpatient psychiatric stays in either an institution for mental disease or the psychiatric ward of an acute care hospital and inpatient hospital substance abuse treatment are not covered.

Topic #7897

Resetting Service Limitations

Service limitations used by a member enrolled in the BadgerCare Plus Benchmark Plan and the BadgerCare Plus Core Plan within their continuous 12-month enrollment year will reset in the following situations:

- A fee-for-service member is enrolled in an HMO (health maintenance organization).
- A member switches from one HMO to another HMO (only allowable within the first 90 days of Core Plan enrollment).
- A member is disenrolled from an HMO and moves to fee-for-service.

Note: When a member goes from fee-for-service into an HMO and subsequently moves back to fee-for-service, service limitations will not be reset for the services that were received under the initial fee-for-service enrollment period.

PA (prior authorization) requests for services beyond the covered service limitations will be denied.

Resetting service limitations does not change a member's Benchmark Plan enrollment year or a member's Core Plan enrollment year.

Topic #1394

Same Day Admission — Death

If a member is admitted and dies before the midnight census on the same day of admission, the member is considered an inpatient.

Topic #1393

Same Day Admission/Discharge — Obstetrical and Newborn Stays

BadgerCare Plus does not have a policy on length of maternity stays. The length of a maternity stay is based on the physician's judgment of what is medically necessary. A woman may elect to be discharged on the same day she delivers. A hospital stay is considered an inpatient stay when a member is admitted to a hospital and delivers a baby, even when the mother and baby are discharged on the date of admission (i.e., they are not included in the midnight census). This policy applies to the baby's stay, as well as the mother's stay, and when the mother and/or newborn are transferred to another hospital.

Topic #824

Services That Do Not Meet Program Requirements

As stated in DHS 107.02(2), Wis. Admin. Code, BadgerCare Plus and Wisconsin Medicaid 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 (Department of Health Services), the PRO (Peer Review Organization) 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 enrollment 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.

Topic #510

Telemedicine

Telemedicine services (also known as "Telehealth") are services provided from a remote location using a combination of interactive video, audio, and externally acquired images through a networking environment between a member (i.e., the originating site) and a Medicaid-enrolled provider at a remote location (i.e., distant site). The services must be of sufficient audio and visual fidelity and clarity as to be functionally equivalent to a face-to-face contact. Telemedicine services do not include telephone conversations or Internet-based communication between providers or between providers and members.

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

Reimbursable Telemedicine Services

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

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

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

- Office or other outpatient services (CPT (Current Procedural Terminology) procedure codes 99201-99205, 99211-99215).
- Office or other outpatient consultations (CPT codes 99241-99245).
- Initial inpatient consultations (CPT codes 99251-99255).
- Outpatient mental health services (CPT codes 90801-90849, 90862, 90875, 90876, and 90887).
- Health and behavior assessment/intervention (CPT codes 96150-96152, 96154-96155).
- ESRD (end-stage renal disease)-related services (CPT codes 90951-90952, 90954-90958, 90960-90961).
- Outpatient substance abuse services (HCPCS (Healthcare Common Procedure Coding System) codes H0022, H0047, T1006).

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

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

Only one eligible provider may be reimbursed per member per DOS (dates of service) for a service provided through

telemedicine unless it is medically necessary for the participation of more than one provider. Justification for the participation of the additional provider must be included in the member's medical record.

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

Services Provided by Ancillary Providers

Claims for services provided through telemedicine by ancillary providers should continue to be submitted under the supervising physician's NPI (National Provider Identifier) using the lowest appropriate level office or outpatient visit procedure code or other appropriate CPT code for the service performed. These services must be provided under the direct on-site supervision of a physician and documented in the same manner as face-to-face services. Coverage is limited to procedure codes 99211 or 99212, as appropriate.

Federally Qualified Health Centers and Rural Health Clinics

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

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

Members Located in Nursing Homes

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

Out-of-State Providers

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

Documentation Requirements

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

Eligible Members

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

Telemedicine and Enhanced Reimbursement

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

Originating Site Facility Fee

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

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

Claim Submission

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

Code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Facilities for Developmental Disabilities

55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Nonresidential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

Outpatient Hospital Reimbursement

Wisconsin Medicaid will reimburse outpatient hospitals only the facility fee (Q3014) for the service. Wisconsin Medicaid will not separately reimburse an outpatient hospital the rate-per-visit for that member unless other covered outpatient hospital services are also provided beyond those included in the telemedicine service on the same DOS. Professional services provided in the outpatient hospital are separately reimbursable.

Store and Forward Services

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

Health Professional Shortage Areas

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

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

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

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

Topic #1392

Transfers

Patient transfers may be reviewed by the ERO (External Review Organization) or the DHS (Department of Health Services) for medical necessity. If the transfer is determined to have been medically necessary, both the transferring and receiving hospital will be paid the full DRG (Diagnosis Related Group) amount for the patient's discharge.

HealthCheck "Other Services"

Topic #22

Definition of HealthCheck "Other Services"

HealthCheck is a federally mandated program known nationally as EPSDT (Early and Periodic Screening, Diagnosis, and Treatment). 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 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, BadgerCare Plus Benchmark Plan, and Medicaid members under 21 years of age.

Topic #1

Prior Authorization

To receive PA (prior authorization) 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 (Prior Authorization Request Form, F-11018 (07/12)) (or PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/12)), or PA/HIAS1 (Prior Authorization Request for Hearing Instrument and Audiological Services 1, F-11020 (07/12)).
  - 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.

Topic #41

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 (prior authorization) 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.

ForwardHealth 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.

Noncovered Services

Topic #9337

Basic Plan Noncovered Services

The following are among the services that are not covered under the BadgerCare Plus Basic Plan:

- Case management.
- Certain visits over the 10-visit limit.
- CRS (Community Recovery Services).
- Enteral nutrition.
- HealthCheck.
- Health education services.
- Hearing services, including hearing instruments, cochlear implants, and bone-anchored hearing aids, hearing aid batteries, and repairs.
- Home care services (home health, personal care, PDN (private duty nursing)).
- Inpatient mental health and substance abuse treatment services.
- Non-emergency transportation (i.e., common carrier, SMV (specialized medical vehicle)).
- Nursing home.
- Obstetrical care and delivery.
- Outpatient mental health and substance abuse services.
- PNCC (prenatal care coordination).
- Provider-administered drugs.
- Routine vision examinations billed with CPT (Current Procedural Terminology) codes 92002-92014 (without a qualifying diagnosis), determination of refractive state billed with CPT code 92015; vision materials such as glasses, contact lenses, and ocular prosthetics; repairs to vision materials; and services related to the fitting of contact lenses and spectacles.
- SBS (school-based services).
- Transplants and transplant-related services.

Billing Members for Noncovered Services

Basic Plan members may request noncovered services from providers. In those cases, providers may collect payment for the noncovered service from the member if the member accepts responsibility for payment and makes payment arrangements with the provider. Providers are strongly encouraged to obtain a written statement in advance documenting that the member has accepted responsibility for payment of the service.

Providers may bill members up to their usual and customary charge for noncovered services. Basic Plan members do not have appeal rights for noncovered services.

Topic #9538

Transplant and transplant-related services are not covered under the BadgerCare Plus Basic Plan.

Topic #5517

Core Plan Noncovered Services

The following services are not covered under the BadgerCare Plus Core Plan:

- Case management.
- CRS (Community Recovery Services).
- Enteral nutrition products.
- Hearing services, including hearing instruments, cochlear implants, bone-anchored hearing aids, hearing aid batteries, and repairs.
- Home care services (home health, personal care, PDN (private duty nursing)).
- Inpatient mental health and substance abuse treatment services.
- Non-emergency transportation (i.e., common carrier, SMV (specialized medical vehicle)).
- Nursing home.
- PNCC (prenatal care coordination).
- Routine vision examinations billed with CPT (Current Procedural Terminology) codes 92002-92014 (without a qualifying diagnosis), determination of refractive state billed with CPT code 92015; vision materials such as glasses, contact lenses, and ocular prosthetics; repairs to vision materials; and services related to the fitting of contact lenses and spectacles.
- SBS (school-based services).

Services that exceed a service limitation established under the Core Plan are considered noncovered. Providers are required to follow certain procedures for billing members who receive these services.

Billing Members for Noncovered Services

Services rendered during a noncovered home health visit will not be reimbursed by ForwardHealth. 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. Providers may bill members up to their usual and customary charges for noncovered services.

Topic #68

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.

Topic #104

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 (Centers for Medicare and Medicaid Services) 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 for NEMT (non-emergency medical transportation) services. Most members may receive NEMT services through LogistiCare. Refer to the NEMT service area for more information.
- 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

Surgery Services

Topic #557

Abortions

Coverage Policy

In accordance with s. 20.927, Wis. Stats., abortions are covered when one of the following situations exists:

- The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests, based on his or her best clinical judgment, that the abortion meets this condition by signing a certification.
- In a case of sexual assault or incest, provided that prior to the abortion the physician attests that sexual assault or incest has occurred, to his or her belief, by signing a written certification; the crime must also be reported to the law enforcement authorities.
- Due to a medical condition existing prior to the abortion, provided that prior to the abortion the physician attests, based on his or her best clinical judgment, that the abortion meets the following condition by signing a certification that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman.

When submitting a claim to ForwardHealth, physicians are required to attach or upload via the ForwardHealth Portal a completed and signed certification statement attesting to one of the previous circumstances. The optional Abortion Certification Statements (F-1161 (10/08)) form is available to use in this situation. Providers may develop a form of their own, as long as it includes the same information.

Covered Services

When an abortion meets the state and federal requirements for Medicaid payment, office visits and all other medically necessary related services are covered. Treatment for complications arising from an abortion are covered, regardless of whether or not the abortion itself is a covered service, because the complications represent new conditions, and thus the services are not directly related to the performance of an abortion.

Coverage of Mifeprex

Wisconsin Medicaid reimburses for Mifeprex under the same coverage policy that it reimburses other surgical or medical abortion procedures under s. 20.927, Wis. Stats.

When submitting claims for Mifeprex, providers are required to:

- Use the HCPCS (Healthcare Common Procedure Coding System) code S0190 (Mifepristone, oral, 200 mg) for the first dose of Mifeprex, along with the E&M (evaluation and management) code that reflects the service provided. Do not use HCPCS code S0199; bill components (i.e., ultrasounds, office visits) of services performed separately.
- Use the HCPCS code S0191 (Misoprostol, oral, 200 mcg), for the drug given during the second visit, along with the E&M code that reflects the service provided. Do not use HCPCS code S0199; bill components (i.e., ultrasounds, office visits) of services performed separately.
- For the third visit, use the E&M code that reflects the service provided.
- Include the appropriate ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) abortion diagnosis code with each claim submission.
- Attach to each claim a completed abortion certification statement that includes information showing the situation is one in

which the abortion is covered.

Note: ForwardHealth denies claims for Mifeprex reimbursement when billed with an NDC (National Drug Code).

Physician Counseling Visits Under s. 253.10, Wis. Stats.

Section 253.10, Wis. Stats., provides that a woman's consent to an abortion is not considered informed consent unless at least 24 hours prior to an abortion a physician has, in person, orally provided the woman with certain information specified in the statute.

Pursuant to this statute, the DHS (Department of Health Services) has issued preprinted material summarizing the statutory requirements and a patient consent form. Copies of these materials may be obtained by writing to the following address:

Administrator
Division of Public Health
PO Box 2659
Madison WI 53701-2659

An office visit during which a physician provides the information required by this statute is covered.

Services Incidental to a Noncovered Abortion

Services incidental to a noncovered abortion are not covered. Such services include, but are not limited to, any of the following services when directly related to the performance of a noncovered abortion:

- Anesthesia services.
- Laboratory testing and interpretation.
- Recovery room services.
- Transportation.
- Routine follow-up visits.
- Ultrasound services.

Topic #581

Hysterectomies

An Acknowledgment of Receipt of Hysterectomy Information (F-1160A (10/08)) form must be completed prior to a covered hysterectomy, except in the circumstances noted below.

The form can be attached to the paper 1500 Health Insurance Claim Form. This form can also be uploaded via the ForwardHealth Portal for electronically submitted claims or providers may submit a paper claim and send the attachment electronically. Wisconsin Medicaid does not cover a hysterectomy for uncomplicated fibroids, fallen uterus, or retroverted uterus.

A hysterectomy may be covered *without* a valid acknowledgment form if one of the following circumstances applies:

- The member was already sterile. Sterility may include menopause. (The physician is required to state the cause of sterility in the member's medical record.)
- The hysterectomy was required as the result of a life-threatening emergency situation in which the physician determined that a prior acknowledgment of receipt of hysterectomy information was not possible. (The physician is required to describe the nature of the emergency.)
- The hysterectomy was performed during a period of retroactive member eligibility and one of the following circumstances applied:

- The member was informed before the surgery that the procedure would make her permanently incapable of reproducing.
- The member was already sterile.
- The member was in a life-threatening emergency situation which required a hysterectomy.

For all of the exceptions previously listed, the physician is required to identify, in writing, the applicable circumstance and attach the signed and dated documentation to the paper claim. (A copy of the preoperative history/physical exam and operative report is usually sufficient.)

The Acknowledgment of Receipt of Hysterectomy Information form is not to be used for purposes of consent of sterilization. Wisconsin Medicaid does not cover hysterectomies for the purposes of sterilization.

Topic #1584

Sterilizations

General Requirements

A sterilization is any surgical procedure performed with the *primary* purpose of rendering an individual permanently incapable of reproducing. The procedure may be performed in an "open" or laparoscopic manner. This does not include procedures that, while they may result in sterility, have a different purpose such as surgical removal of a cancerous uterus or cancerous testicles.

Medicaid reimbursement for sterilizations is dependent on providers fulfilling all federal and state requirements and satisfactory completion of a Consent for Sterilization form (F-1164 (10/08)). There are no exceptions. Federal and state regulations require the following:

- The member is not an institutionalized individual.
- The member is at least 21 years old on the date the informed written consent is obtained.
- The member gives voluntary informed written consent for sterilization.
- The member is not a mentally incompetent individual. A "mentally incompetent" individual is defined as a person who is declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purposes, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.
- At least 30 days, excluding the consent and surgery dates, but not more than 180 days, must pass between the date of written consent and the sterilization date, except in the case of premature delivery or emergency abdominal surgery if:
  - In the case of premature delivery, the sterilization is performed at the time of premature delivery *and* written informed consent was given at least 30 days before the expected date of delivery *and* at least 72 hours before the premature delivery. The 30 days excludes the consent and surgery dates.
  - The sterilization is performed during emergency abdominal surgery *and* at least 72 hours have passed since the member gave written informed consent for sterilization.

Consent for Sterilization Form

A member must give voluntary written consent on the federally required Consent for Sterilization form. Sterilization coverage requires accurate and thorough completion of the consent form. The physician is responsible for obtaining consent. Any corrections to the form must be signed and dated by the physician and/or member, as appropriate.

Signatures and signature dates of the member, physician, and the person obtaining the consent are mandatory. Providers' failure to comply with any of the sterilization requirements results in denial of the sterilization claims.

To ensure reimbursement for sterilizations, providers are urged to use the Consent for Sterilization form before *all* sterilizations in the event that the patient obtains retroactive enrollment.

Topic #1400

Transplant Services

The following transplants and the cost of the organs are covered, when appropriate and medically necessary, in approved hospitals as determined by ForwardHealth:

- Cornea.
- Heart.
- Kidney.
- Liver.
- Lung.
- Pancreas.
- Small bowel.
- Bone marrow with PA (prior authorization).
- Hematopoietic stem cell, with PA.
- Other medically-necessary transplants, with PA.

Transplants involving combinations of the above solid organs (e.g., heart-lung) are also covered.

Before making a referral to an approved institution, hospitals and physicians are required to contact the facility to determine whether the facility currently accepts ForwardHealth program member referrals.

Transplant hospitals are required to be members of the Organ Procurement and Transplantation Network or approved by the CMS (Centers for Medicare and Medicaid Services) and have written protocols for identifying potential organ donors. Refer to the data page of the Organ Procurement and Transplantation Network for UNOS (United Network for Organ Sharing)-approved organ transplant centers.

Hospitals are required to obtain all organs through the OPO (organ procurement organization) designated under 42 CFR Part 486. A hospital that procures an organ in-house must abide by the rules of protocol as established by its respective OPO.

Wisconsin Medicaid does not reimburse providers for organ transplants or transplant-related services provided to illegal aliens.

Cost Reports for Transplant Services

All paid transplant claims are required to be included in the Medicaid portion of the filed cost report. Refer to the Inpatient Hospital State Plan for information on cost reports. In addition, hospitals are required to prepare a separate Schedule D-6, Part I, of the Inpatient Hospital State Plan on the cost report for every type of organ acquisition cost for those transplants performed.

The following is a partial list of Wisconsin Medicaid-allowable organ transplant institutions:

Type of Transplant	Facility
Bone marrow	May be done at any Wisconsin Medicaid-approved facility.
Heart	• Abbott Northwestern Hospital — Chicago, IL. • Children's Hospital of Wisconsin — Milwaukee, WI. • Fairview University Medical Center (University of Minnesota Hospital and Clinics) — Minneapolis, MN.

	• Froedtert Memorial Lutheran Hospital — Milwaukee, WI. • Mayo Clinic (St. Mary's Hospital) — Rochester, MN. • St. Luke's Medical Center — Milwaukee, WI. • University of Wisconsin Hospital and Clinics — Madison, WI. • Other out-of-state hospitals approved by Medicare.
Heart-lung	• Children's Hospital of Wisconsin — Milwaukee, WI. • Fairview University Medical Center (University of Minnesota Hospital and Clinics) — Minneapolis, MN. • Froedtert Memorial Lutheran Hospital — Milwaukee, WI. • St. Luke's Medical Center — Milwaukee, WI. • University of Wisconsin Hospital and Clinics — Madison, WI. • Other out-of-state hospitals approved by Medicare.
Kidney	May be done at any Medicare-approved facility.
Liver	• Children's Hospital of Wisconsin — Milwaukee, WI. • Fairview University Medical Center (University of Minnesota Hospital and Clinics) — Minneapolis, MN. • Froedtert Memorial Lutheran Hospital — Milwaukee, WI. • St. Luke's Medical Center — Milwaukee, WI. • University of Wisconsin Hospital and Clinics — Madison, WI. • Other out-of-state hospitals approved by Medicare.
Lung	• Children's Hospital of Wisconsin — Milwaukee, WI. • Fairview University Medical Center (University of Minnesota Hospital and Clinics) — Minneapolis, MN. • Froedtert Memorial Lutheran Hospital — Milwaukee, WI. • University of Wisconsin Hospital and Clinics — Madison, WI. • Other out-of-state hospitals approved by Medicare.
Pancreas	• Fairview University Medical Center (University of Minnesota Hospital and Clinics) — Minneapolis, MN.

	• Froedtert Memorial Lutheran Hospital — Milwaukee, WI. • University of Wisconsin Hospital and Clinics — Madison, WI. • Other out-of-state hospitals approved by Medicare.

EHR Incentive Program

4

Archive Date:01/02/2013

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

Topic #12102

Adopting EHR Technology

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

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

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

Topic #12167

Attesting to Eligibility Standards

The Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program application will require attestation for adopting, implementing, or upgrading certified EHR technology or the "meaningful use" of that certified EHR technology to determine eligibility for the Wisconsin Medicaid EHR Incentive Program. Eligible Hospitals must attest to adopt, implement, or upgrade or "meaningful use" of certified EHR technology based on the following conditions:

- Eligible Hospitals participating in both the Medicare and Medicaid EHR Incentive Programs will be required to attest to the "meaningful use" of their certified EHR technology if the Eligible Hospital has demonstrated "meaningful use" to CMS for their Medicare EHR Incentive Program application.
- Eligible Hospitals participating in only the Wisconsin Medicaid EHR Incentive Program (i.e., Eligible Hospitals not participating in both the Medicare and Medicaid EHR Incentive Program during the same payment year) must attest to adoption, implementation, or upgrade.

Topic #12103

Implementing EHR Technology

In order to qualify for a Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payment under "implementation," Eligible Professionals and Eligible Hospitals must meet the criteria for adopting certified EHR technology and demonstrate actual implementation, installation, or utilization of certified EHR technology. Examples of how to demonstrate

implementation of certified EHR technology includes completing a workflow analysis and redesign, training staff on the use of modules, and patient demographics and administrative data. All information is subject to audit at any time and must be maintained by the Eligible Professional or Eligible Hospital for a period of six years. If selected for audit, the applicant must be able to supply at least one document from each of the following lists:

List One:

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

List Two:

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

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

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

Topic #12104

Upgrading EHR Technology

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

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

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

Topic #12497

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

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

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

An Overview

Topic #12157

Overview of the EHR Incentive Program

The EHR (Electronic Health Record) Incentive Program was established under the American Recovery and Reinvestment Act of 2009, also known as the Stimulus Bill, to encourage eligible health care professionals and hospitals to adopt and show meaningful use of certified EHR technology.

Under the federal law, Medicare and Medicaid have separate EHR incentive programs. Acute care and CAH (critical access hospitals) may participate in both the Wisconsin Medicaid EHR Incentive Program and the Medicare EHR Incentive Program. Children's hospitals may only participate in the Wisconsin Medicaid EHR Incentive Program. All hospitals must be Wisconsin Medicaid-enrolled to participate in the Wisconsin Medicaid EHR Incentive Program.

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

Payments to Eligible Hospitals will be made within 45 days of the approval of a Wisconsin Medicaid EHR Incentive Program application. Eligible Hospitals who meet all of the requirements may receive an incentive payment once per FFY (federal fiscal year). Providers are required to wait at least 90 days between submitting applications for the Wisconsin Medicaid EHR Incentive Program for different FFYs.

The Wisconsin Medicaid EHR Incentive Program will be available for Eligible Hospitals from 2011 until 2018, although September 30, 2015, is the last date Eligible Hospitals may initiate participation in the Wisconsin Medicaid EHR Incentive Program. Eligible Hospitals may participate in the program for up to three years.

The Wisconsin Medicaid EHR Incentive Program payment years are defined by federal regulation as the FFY. Payment years are based on the FFY with the fiscal year beginning on October 1 of the prior calendar year and extending to September 30 of the relevant year. Payment years are constructed in the following way:

- First payment year: Eligible Hospitals only participating in the Wisconsin Medicaid EHR Incentive Program are required to attest to adopting, implementing, or upgrading certified EHR technology. If the Eligible Hospital participates in both the Medicare EHR Incentive Program and the Wisconsin Medicaid EHR Incentive Program and demonstrates "meaningful use" to CMS, the Eligible Hospital must also attest to "meaningful use" to the Wisconsin Medicaid EHR Incentive Program.
- Second payment year: Eligible Hospitals are required to demonstrate "meaningful use" of certified EHR technology during any 90-day continuous period, known as the EHR reporting period, during the payment year.
- Third payment year: Eligible Hospitals are required to demonstrate "meaningful use" of certified EHR technology for the entire payment year (FFY).

Eligible Hospitals will have an additional 90-day grace period after the end of the payment year to apply for an incentive payment for the previous Program Year. The payment year for Eligible Hospitals is based on the FFY (i.e., October 1 through September 30).

Eligible Hospitals should note that prior to October 1, 2016, Eligible Hospitals are not required to participate in consecutive years for the Wisconsin Medicaid EHR Incentive Program. However, on and after October 1, 2016, Eligible Hospitals must participate in consecutive years and must have received at least one payment before October 1, 2016. For example, an Eligible Hospital may apply and complete all requirements for the first year in 2011 and receive a payment but then wait until 2013 to demonstrate

"meaningful use" during a 90-day continuous period for the second payment year.

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

Appeals

Topic #12137

Appeals Process

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

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

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

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

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

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

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

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

Topic #12477

Valid Reasons to Appeal

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

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

Appealing a Payment Amount

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

Appealing a Denied Wisconsin Medicaid Electronic Health Record Incentive Program Application

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

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

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

Denied Application Appeals	
Reason for Appeal	**Documentation Needed**
The patient volume required by the CMS (Centers for Medicare and Medicaid Services) have not been met, see federal rule 42 CFR 495.304.	• For Eligible Hospitals, provide the out-of-state patient volume for the reported 90-day period on the Wisconsin Medicaid EHR Incentive Program application. • For Eligible Professionals, provide the patient volume for the reported 90-day period on the Wisconsin Medicaid EHR Incentive Program application.
The Eligible Hospital has indicated it is not an acute care hospital with an average length of stay of 25 days or less or a children's hospital.	Acute care and children's hospitals are required to have an average length of stay for patients of 25 days or less to qualify for the Wisconsin Medicaid EHR Incentive Program. If the question was answered incorrectly when completing the original Wisconsin Medicaid EHR Incentive Program application, provide a clarifying statement indicating the reason why the Eligible Hospital meets the requirements for the program.
The Eligible Hospital did not confirm to only participate in the Wisconsin Medicaid EHR Incentive Program.	Eligible Hospitals must agree to participate in only one state's Medicaid EHR Incentive Program. If the question was answered incorrectly when completing the original Wisconsin Medicaid EHR Incentive Program application, provide a clarifying statement that the Eligible Hospital confirms to only participate in the Wisconsin Medicaid EHR Incentive Program.

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

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

Eligibility

Topic #12158

Eligible Hospitals for EHR Incentive Program

Acute care and CAHs (critical access hospitals) may participate in both the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program and the Medicare EHR Incentive Program. Children's hospitals may only participate in the Wisconsin Medicaid EHR Incentive Program. All hospitals must be Wisconsin Medicaid-enrolled to participate in the Wisconsin Medicaid EHR Incentive Program.

Acute care and CAHs are required to have an average length of stay for patients of 25 days or less and have a CCN (Centers for Medicare and Medicaid Services Certification Number) that has the last four digits in the series of 0001-0879 or 1300-1399.

Children's hospitals are required to be classified by CMS as a children's hospital, either as a free standing hospital or as a hospital within a hospital, and have a CCN in the series of 3300-3399.

Financial Information

Topic #12517

Determining the Payment Year for Eligible Hospitals

When completing the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program application, Eligible Hospitals are asked to enter in the start date of their hospital's own fiscal year, which corresponds to the start date for the Medicare Cost Report from which the Patient Volume Cost data will be sourced. To simplify the process for identifying this start date, each Eligible Hospital will be able to determine what start date to enter at this point in their application based on the table below.

Hospital Fiscal Year Start	2011 payment year	2012 payment year	2013 payment year	2014 payment year	2015 payment year
January	1/1/09 - 12/31/09	1/1/10 - 12/31/10	1/1/11 - 12/31/11	1/1/12 - 12/31/12	1/1/13 -12/31/13
February	2/1/09 - 1/31/10	2/1/10 - 1/31/11	2/1/11 - 1/31/12	2/1/12 - 1/31/13	2/1/13 - 1/31/14
March	3/1/09 - 2/28/10	3/1/10 - 2/28/11	3/1/11 - 2/29/12	3/1/12 - 2/28/13	3/1/13 - 2/28/14
April	4/1/09 - 3/31/10	4/1/10 - 3/31/11	4/1/11 - 3/31/12	4/1/12 - 3/31/13	4/1/13 - 3/31/14
May	5/1/09 - 4/30/10	5/1/10 - 4/30/11	5/1/11 - 4/30/12	5/1/12 - 4/30/13	5/1/13 - 4/30/14
June	6/1/09 - 5/31/10	6/1/10 - 5/31/11	6/1/11 - 5/31/12	6/1/12 - 5/31/13	6/1/13 - 5/31/14
July	7/1/09 - 6/30/10	7/1/10 - 6/30/11	7/1/11 - 6/30/12	7/1/12 - 6/30/13	7/1/13 - 6/30/14
August	8/1/09 - 7/31/10	8/1/10 - 7/31/11	8/1/11 - 7/31/12	8/1/12 - 7/31/13	8/1/13 - 7/31/14
September	9/1/09 - 8/31/10	9/1/10 - 8/31/11	9/1/11 - 8/31/12	9/1/12 - 8/31/13	9/1/13 - 8/31/14
October	10/1/09 -9/30/10	10/1/10 - 9/30/11	10/1/11 - 9/30/12	10/1/12 - 9/30/13	10/1/13 -9/30/14
November	11/1/08 -10/31/09	11/1/09 -10/31/10	11/1/10 -10/31/11	11/1/11 -10/31/12	11/1/12 -10/31/13
December	12/1/08 -11/30/09	12/1/09 -11/30/10	12/1/10 -11/30/11	12/1/11 -11/30/12	12/1/12 -11/30/13

Topic #12169

Electronic Funds Transfer Required

All Eligible Hospitals are required to use an EFT (electronic funds transfer) when participating in the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. An EFT allows ForwardHealth to directly deposit payments into the Eligible Hospital's designated bank account for a more efficient delivery of payments. EFTs are secure, eliminate paper, and reduce the uncertainty of possible delays in mail delivery. Refer to the Electronic Funds Transfer User Guide on the Portal User Guides page of the Providers area of the ForwardHealth Portal for information on EFT enrollment.

Topic #12165

Electronic Health Record Incentive Program Eligible Hospital Incentive Payment Calculation

The "Aggregate Wisconsin Medicaid EHR (Electronic Health Record) Hospital Incentive Program Payment Amount" calculation

below determines the total incentive payment amount the hospital is eligible to receive over three payment years.

Aggregate Wisconsin Medicaid EHR Hospital Incentive Payment Amount = (Overall EHR Amount) * (Medicaid Share)

Overall EHR Amount = {Sum over 4 years of [(Base Amount + Discharge Related Amount Applicable for Each Year)* Transition Factor Applicable for Each Year]}

Medicaid Share = {(Medicaid Inpatient Bed Days + Medicaid Managed Care Inpatient Bed Days)/ [(Total Inpatient Bed Days) * (Estimated Total Charges - Charity Care Charges) / (Estimated Total Charges)]}

Overall EHR Amount Calculation

The Wisconsin Medicaid EHR Incentive Program will calculate the hospital's incentive payments using the calculation outlined by CMS (Centers for Medicare and Medicaid Services).

The "Overall EHR Amount" is the sum of four years of [(Base Amount + Discharge Related Amount applicable for each year) * Transition Factor applicable for each year].

Overall EHR Amount Components		
Data Input Name	**Description**	**Source of Data**
Base amount	$2,000,000	Statute defined
Discharge related amount	$200 * (the 1,150th through the 23,000th discharge is eligible for inclusion. For year one, use most recent year of data. For subsequent years, use discharges adjusted for the hospital's average annual rate of growth for the most recent three years for which data is available per year).	Discharges from historical years (prior to 2010) will come from Medicare Cost Report — CMS 2552-96 Worksheet S-3 Part I, column 15, line 12. Discharges from current years (2010 and beyond) will come from Medicare Cost Report — CMS 2552-10 Worksheet S-3 Part I, column 15, line 14.
Transition factor	Year 1 = 1 Year 2 = 0.75 Year 3 = 0.50 Year 4 = 0.25	Statute defined

Discharge Related Amount Calculation

To determine the "discharge related amount," Eligible Hospitals will need to calculate their average annual growth rate to be applied to the base year of discharges.

Sample Average Annual Growth Rate Calculation

Eligible Hospitals may find it useful to refer to this sample calculation:

Hospital Fiscal Year 2010: 2,000 Base Year (BY).
Hospital Fiscal Year 2009: 1,900 BY (-1).
Hospital Fiscal Year 2008: 1,720 BY (-2).

Hospital Fiscal Year 2007: 1,500 BY (-3).

Formula	Calculation	Annual Growth Rate
(BY [-2] - BY [-3]) / BY (-3)	(1,720 - 1,500) / 1,500	0.147
(BY [-1] - BY [-2]) / BY (-2)	(1,900 - 1,700) / 1,720	0.105
(BY - BY [-1]) / BY (-1)	(2,000 - 1,900) / 1,900	0.053

Average Annual Growth Rate = (0.147 + 0.105 + 0.053) / 3 = 0.102

Once the average annual growth rate is determined, it is applied to the most recent year's discharges in order to determine the discharge related amount.

Discharge Related Amounts Applicable for Each Year

Discharges

Hospital Fiscal Year One (Y1) = 2,000 (base year)
Hospital Fiscal Year Two (Y2) = 2,000 (Y1) * 1.102 (average annual growth rate) = 2,204
Hospital Fiscal Year Three (Y3) = 2,204 (Y2) * 1.102 (average annual growth rate) = 2,429
Hospital Fiscal Year Four (Y4) = 2,429 (Y3) * 1.102 (average annual growth rate) = 2,677

Calculation: Hospital Fiscal Year X = 200 * (Discharge per Calculation Year X [Total Discharges less 1,149 with maximum value of 21,851]) = Discharge Related Amount

Note: Only the 1,150th through the 23,000th discharge is eligible to be counted in the calculation of the Discharge Related Amount for each year.

Sample Discharge Related Amount Calculation

Hospital Fiscal Year One (Y1) = 200 * (2,000 - 1,149) = 170,200
Hospital Fiscal Year Two (Y2) = 200 * (2,204 - 1,149) = 211,000
Hospital Fiscal Year Three (Y3) = 200 * (2,429 - 1, 149) = 256,000
Hospital Fiscal Year Four (Y4) = 200 * (2,677 - 1,149) = 305,600

After determining the discharge related amount, the transition factor and base amount need to be applied.

Sample Overall EHR Amount

Hospital Fiscal Year One (Y1) = (2,000,000 + 170,200) * 1 = $2,170,200
Hospital Fiscal Year Two (Y2) = (2,000,000 + 211,000) * 0.75 = $2,170,200
Hospital Fiscal Year Three (Y3) = (2,000,000 + 256,000) * 0.50 = $1,128,000
Hospital Fiscal Year Four (Y4) = (2,000,000 + 305,600) * 0.25 = $576,400

Overall EHR Amount = Sum of all four years = **$5,532,850**

Medicaid Share Calculation

Once Eligible Hospitals have determined what the "Overall EHR Amount" is for the hospital, they will have to calculate the "Medicaid Share." For Eligible Hospitals to figure out what the total incentive payment will be, the "Overall EHR Amount" is multiplied by the Medicaid Share. To determine this amount, Eligible Hospitals should refer to this calculation:

Medicaid Share = {(Estimated Medicaid inpatient bed days + estimated Medicaid Managed Care inpatient days) / [(Estimated total inpatient bed days) * (Estimated total charges - charity care charges) / (Estimated total charges)]}

Medicaid Share Components		
Data Input Name	**Source of Data**	**Sample Data**
Estimated Medicaid inpatient bed days*	Medicaid fee-for-service and managed care inpatient bed days for the Eligible Hospital's cost reporting period. Wisconsin Medicaid will provide Eligible Hospitals this data.	7,000
Estimated total inpatient bed days	Medicare Cost Report CMS 2552-10 Worksheet S-3, Part 1, Column 8, sum of lines 8-12.	21,000
Estimated total charges	Medicare Cost Report CMS 2552-10 Worksheet C, Part 1, Column 8, line 200.	10,000,000
Charity Care Charges	Medicare Cost Report 2552-10, Worksheet S-10, column 3, line 20.	$1,300,000

* Hospitals participating in both Medicare and Medicaid EHR Incentive Programs (dual eligible hospitals): For the purpose of calculating the Medicaid share, a patient cannot be counted in the numerator if they would also count for purposes of calculating the Medicare share.

Sample Medicaid Share Calculation

Medicaid Share = (7000) / {21,000 * (10,000,000 - 1,300,000) / 10,000,000}
Medicaid Share = 0.38

Aggregate Wisconsin Medicaid EHR Hospital Incentive Payment Amounts - Sample Calculations

To figure out what the amounts of their Wisconsin Medicaid EHR Incentive Program incentive payments will be, they must calculate the Aggregate EHR Incentive Payment Amount. To determine this amount, Eligible Hospitals should refer to the following calculation.

Aggregate EHR Hospital Incentive Payment Amount = Overall EHR Amount * Medicaid Share
(Based on previous sample calculations)
Aggregate EHR Hospital Incentive Payment Amount = $5,532,850 * 0.38 = $2,102,483

The Wisconsin Medicaid EHR Incentive Program will distribute the Eligible Hospital's Medicaid EHR incentive payment over three years in the following percentages:

- Year one of participation: 50 percent of the aggregate EHR incentive payment amount.
- Year two of participation: 40 percent of the aggregate EHR incentive payment amount.
- Year three of participation: 10 percent of the aggregate EHR incentive payment amount.

Participation Year	Aggregate EHR Amount	Percentage	Payment Amount
Year One	$2,102,483	50%	$1,051,241.50
Year Two	$2,102,483	40%	$840,993.20
Year Three	$2,102,483	10%	$210,248.30

Topic #12164

Information Needed to Determine the Incentive Payment Amount

Eligible Hospitals will need to enter the following information for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program to determine the payment amount:

- Four years' worth of discharge data from the most recently submitted Medicare Cost Report period (supplied by the Eligible Hospital. Discharge Data for the current years [2010 and beyond] can be found on the most recently submitted Medicare Cost Report 2552-10, Worksheet S-3, Part 1, Column 15, line 14. Discharge Data from historical years [prior to 2010] can be found on Medicare Cost Report 2552-96, Worksheet S-3, Part 1, Column 15, line 12).
- Estimated eligible member inpatient bed days (supplied to the Eligible Hospital by the Wisconsin Medicaid EHR Incentive Program).
- Estimated eligible member managed care inpatient bed days (supplied to the Eligible Hospital by the Wisconsin Medicaid EHR Incentive Program).
- Estimated total inpatient bed days (supplied by the Eligible Hospital. Data can be found on the most recently submitted Medicare Cost Report Worksheet S-3, Part 1, Column 8, sum of lines 1 and 8-12).
- Estimated total charges (supplied by the Eligible Hospital. Data can be found on the most recently submitted Medicare Cost Report Worksheet C, Part 1, Column 8, line 200).
- Estimated total charity care charges (supplied by the Eligible Hospital. Data can be found on the most recently submitted Medicare Cost Report 2552-10, Worksheet S-10, line 20).

Note: Dual-eligible hospitals may not count patients in the numerator when calculating the Medicaid share if they would also be counted for purposes of calculating the Medicare share.

The Wisconsin Medicaid EHR Incentive Program will calculate the incentive payments for Eligible Hospitals using the data points listed above.

Cost Data for Eligible Hospitals

There are two versions of the Medicare Cost reports. This table below lists where the information to determine the payment amount can be found for the 2552-10 and 2552-96 the Medicare Cost Reports.

Data Point Needed	If you have the 2552-10 form (revision date July 2, 2009)	If you have the 2552-96 form (revision date May, 1,2004)
Total Discharges	Worksheet S-3, Part 1, Column 15, Line 14	Worksheet S-3, Part 1, Column 15, Line 12
Total Medicaid Inpatient Bed Days	Distributed by the Department of Health Services	Distributed by the Department of Health Services
Total Inpatient Bed Days	Worksheet S-3, Part 1, Column 8, sum of Lines 1 and 8-12	Worksheet S-3, Part 1, Column 6, sum of Lines 1 and 6-10
Total Charges — All Discharges	Worksheet C, Part 1, Column 8, Line 200	Worksheet C, Part 1, Column 8, Line 101
Total Charges Charity Care	Worksheet S-10, Column 3, Line 20	Worksheet S-10, Line 30

Topic #12168

Payment Distribution

Eligible Hospitals who meet all of the requirements will receive an incentive payment once per FFY (federal fiscal year). The Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program will calculate the aggregate EHR incentive payment amount the first year of participation. Eligible Hospitals should note that they will receive one payment per CCN (Centers for Medicare and Medicaid Services Certification Number). The Wisconsin Medicaid EHR Incentive Program will distribute the hospital's Medicaid EHR incentive payment over three years in the following percentages:

- Year one of participation: 50 percent of the aggregate EHR incentive payment amount.
- Year two of participation: 40 percent of the aggregate EHR incentive payment amount.
- Year three of participation: 10 percent of the aggregate EHR incentive payment amount.

Topic #12119

Remittance Advice

Financial Transactions Section

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

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

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

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

Summary Section

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

Meaningful Use of Certified EHR Technology

Topic #12167

Attesting to Eligibility Standards

The Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program application will require attestation for adopting, implementing, or upgrading certified EHR technology or the "meaningful use" of that certified EHR technology to determine eligibility for the Wisconsin Medicaid EHR Incentive Program. Eligible Hospitals must attest to adopt, implement, or upgrade or "meaningful use" of certified EHR technology based on the following conditions:

- Eligible Hospitals participating in both the Medicare and Medicaid EHR Incentive Programs will be required to attest to the "meaningful use" of their certified EHR technology if the Eligible Hospital has demonstrated "meaningful use" to CMS for their Medicare EHR Incentive Program application.
- Eligible Hospitals participating in only the Wisconsin Medicaid EHR Incentive Program (i.e., Eligible Hospitals not participating in both the Medicare and Medicaid EHR Incentive Program during the same payment year) must attest to adoption, implementation, or upgrade.

Topic #12166

Meaningful Use of Certified EHR Technology for Dual-Eligible Hospitals

Eligible Hospitals may participate in both the Medicare EHR (Electronic Health Record) Incentive Program and the Wisconsin Medicaid EHR Incentive Program. If the Eligible Hospital participates in both the Medicare EHR Incentive Program and the Wisconsin Medicaid EHR Incentive Program and demonstrates "meaningful use" to CMS (Centers for Medicare and Medicaid Services), the Eligible Hospital must also attest to "meaningful use" to the Wisconsin Medicaid EHR Incentive Program. Eligible Hospitals do not need to demonstrate "meaningful use" to the Wisconsin Medicaid EHR Incentive Program as CMS will share the Eligible Hospital's meaningful use information submitted to CMS with the Wisconsin Medicaid EHR Incentive Program. The Wisconsin Medicaid EHR Incentive Program will not approve an Eligible Hospital's application until CMS communicates approval of the meaningful use measures reported. It may take up to 45 days for CMS to approve the reported meaningful use information and communicate that approval to the Wisconsin Medicaid EHR Incentive Program.

While completing the "meaningful use" portion of the Wisconsin Medicaid EHR Incentive Program application, Eligible Hospitals will be required to provide the start date of the 90-day EHR reporting period in which they demonstrated "meaningful use" while registering at the R&A (Medicare and Medicaid EHR Incentive Program Registration and Attestation System). The Wisconsin Medicaid EHR Incentive Program application will then calculate the ending date for this EHR reporting period and will ask all Eligible Hospitals to confirm this reporting period.

Important steps for dual-Eligible Hospitals include the following:

- First register and attest for the Medicare EHR Incentive Program payment.
- Complete attestation and submission of meaningful use measures to the Medicare EHR Incentive Program.
- After completion of the Medicare EHR Incentive Program application, begin the Wisconsin Medicaid EHR Incentive Program application.
- Once CMS has determined if meaningful use requirements are met, CMS will communicate meaningful use determination (eligible or ineligible) to the Wisconsin Medicaid EHR Incentive Program within 45 days of determination.

- Only after receipt of confirmation that meaningful use requirements have been met will the Wisconsin Medicaid EHR Incentive Program begin to process the application.
- Eligible Hospitals should note that if an Eligible Hospital is not deemed a meaningful user of certified EHR technology by the Medicare EHR Incentive Program, the Eligible Hospital cannot be deemed a meaningful user by the Wisconsin Medicaid EHR Incentive Program. This will result in a denial of the Wisconsin Medicaid EHR Incentive Program application.

Topic #13197

Meaningful Use of Certified EHR Technology for Eligible Hospitals

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

The American Recovery and Reinvestment Act of 2009 specifies three main components of meaningful use:

- The use of a certified EHR in a meaningful manner, such as e-prescribing.
- The use of certified EHR technology for electronic exchange of health information to improve the quality of health care.
- The use of certified EHR technology to submit clinical quality and other measures.

In short, meaningful use means Eligible Hospitals need to demonstrate that they are using EHR technology in ways that can be measured in quality and quantity.

Topic #13237

Requirements for Stage One of Meaningful Use for Wisconsin Medicaid-Only Eligible Hospitals

The requirements for stage one of meaningful use includes both a "core set" and a "menu set" of objectives that are specific to Eligible Hospitals. There are a total of 24 meaningful use objectives. To qualify for a Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payment, 19 of these 24 objectives must be met. Of the 24 objectives, there are 14 required "core set" objectives that must be met. The remaining five "menu set" objectives may be chosen from a list of ten menu set objectives.

Some meaningful use objectives are not applicable to every Eligible Hospital's clinical practice; therefore, they would not have any eligible patients or actions for the measure denominator. In these cases, the Eligible Hospital would be excluded from having to meet that measure. For example, core measure eight of 14 is to "Record smoking status for patients 13 years old or older." Any Eligible Hospital that admits no patients 13 years or older to their inpatient or emergency department is excluded from meeting this measure. Therefore the Eligible Hospital is excluded from this objective and is then only required to attest to 13 of the remaining core set objectives.

Eligible Hospitals should refer to the CMS (Centers for Medicare and Medicaid Services) Web page for a complete table of contents of all core set and menu set objectives. Each objective contains the following information:

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

Additional information may also be included on this Web page regarding the following:

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

Clinical Quality Measures

Clinical quality measures are tools that help measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and systems that are associated with the ability to provide high-quality health care. To demonstrate meaningful use successfully, Eligible Hospitals must report clinical quality measures. Eligible Hospitals must report on all 15 of their clinical quality measures.

Eligible Hospitals should refer to the CMS Web page for complete information on reporting clinical quality measures.

Meaningful Use Denominators

There are two types of percentage-based measures that are included in demonstrating meaningful use:

- The denominator is all patients seen or admitted during the EHR Reporting Period. The denominator is all patients, regardless of whether their records are kept using certified EHR technology or not.
- The denominator is actions or subsets of patients seen or admitted during the EHR Reporting Period. The denominator only includes patients, or actions taken on behalf of those patients, whose records are kept using certified EHR technology.

Eligible Hospitals should refer to their EHR system for meaningful use denominators to be entered into the Wisconsin Medicaid EHR Incentive Program application. Eligible Hospitals should note that each EHR system varies.

Electronic Health Record Reporting Period

The EHR Reporting Period is defined as the timeframe when Eligible Hospitals report meaningful use to the Wisconsin Medicaid EHR Incentive Program. The EHR Reporting Period years are defined as:

- First year: The Eligible Hospital must be able to show meaningful use for a 90-day timeframe that must fall within the FFY (federal fiscal year) that the Eligible Hospital is applying for. For example, if an Eligible Hospital is applying for the 2012 Wisconsin Medicaid EHR Incentive Program payment, the entire 90 day reporting period must fall in FFY 2012.
- Subsequent years: The Eligible Hospital must be able to show meaningful use for the entire FFY for which the Eligible Hospital is applying for the Wisconsin Medicaid EHR Incentive Program payment. For example, if an Eligible Hospital is applying for the 2013 Wisconsin Medicaid EHR Incentive Program, the reporting period must be October 1, 2012 through September 30, 2013.

Topic #13217

Stages of Meaningful Use of Certified EHR Technology

The CMS (Centers for Medicare and Medicaid Services) have split the meaningful use criteria into three stages that will be rolled out over the course of the next five years. As of now, the stages are identified as such:

- Stage one (Program Year 2011 and/or 2012) sets the baseline for electronic data capture and information sharing.
- Stages two and three (at this time expected to be implemented in Program Year 2013) will continue to expand on this baseline and be developed through future rule making.

The table below demonstrates what stage of meaningful use must be reported based upon the first year an Eligible Hospital began participation in the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. Eligible Hospitals should note that they do not need to participate in consecutive Program Years.

First Year of Participation	Program Year				
	2011	2012	2013	2014	2015
2011	AIU (adoption, implementation, or upgrade) or Stage 1 MU (meaningful use)	Stage 1	Stage 2*	Stage 2	TBD
2012		AIU or Stage 1 MU	Stage 1	Stage 2	TBD
2013			AIU or Stage 1 MU	Stage 1	TBD
2014				AIU or Stage 1 MU	TBD

* CMS announced on November 30, 2011, that Stage 2 meaningful use will be delayed for one year for providers who attest during 2011. Stage 2 compliance will be required in 2014, not 2013. Until the Stage 2 Meaningful Use Final Rule is published this is not official policy, therefore it has not been changed in the table above.

Patient Volume

Topic #12557

Alerting Eligible Hospitals for Medicaid Inpatient Bed Days and Patient Volume Eligibility Period

For Program Year 2013, the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program will analyze all Wisconsin hospitals' patient volume during the first 90-day quarter of the FFY (federal fiscal year). If the Eligible Hospital's 90-day FFY quarter eligibility period cannot be established based on patient volume analyzed during the first quarter, the Wisconsin Medicaid EHR Incentive Program will analyze the Eligible Hospital's patient volume for subsequent 90-day quarters to determine if a 90-day FFY quarter eligibility period can be established during Program Year 2013. The Eligible Hospital's 90-day FFY quarter eligibility period for each facility will be communicated to the contact provided during the R&A (Medicare and Medicaid EHR Registration and Attestation System) process.

Eligible Hospitals that have not previously participated in the Wisconsin Medicaid EHR Incentive Program will also receive Medicaid Inpatient Bed Day totals. ForwardHealth policy allows each Wisconsin Hospital to submit all claims one year back from the date of service, which are used to analyze patient volume in this eligibility determination process. Therefore, the Wisconsin Medicaid EHR Incentive Program will be able to begin eligibility determination for all Wisconsin Hospitals starting on January 1 of each calendar year. Eligible Hospitals will not be able to apply for Program Year 2013 until they receive this information.

Topic #12537

Determining the Patient Volume Cost Data Start Date

When completing Part 3 of 3 of the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program application, all Eligible Hospitals will need to "use data from the hospital fiscal year that ends during the FFY (Federal Fiscal Year) prior to the FFY that serves as the first payment year." This part of the application is asking Eligible Hospitals to enter in the start date of their hospital's own fiscal year, which corresponds to the start date for the Medicare Cost Report from which the Patient Volume Cost data will be sourced.

Topic #14997

Eligible Hospitals with Less Than Four Years of Discharge Data

New Eligible Hospitals may apply for an incentive payment through the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program when they have two years of total discharge data (two Medicare cost reports). In the first row of the 'Total Discharges' column, the Eligible Hospital will enter data from the hospital's most recent cost report. In the second, third, and fourth rows of the 'Total Discharges' column, Eligible Hospitals will enter data from the hospital's previous year cost report. Refer to the following table for an example.

The following example is provided to assist Eligible Hospitals with less than four years of total discharge data. In this example, the Eligible Hospital has the following data:

- During FFY (Federal Fiscal Year) October 1, 2010 — September 30, 2011: Total discharges were 5,000.

- During FFY October 1, 2009 — September 30, 2010: Total discharges were 1,000.
- During FFY October 1, 2008 — September 30, 2009: The hospital does not have a cost report. The hospital enters data from the October 1, 2009 — September 30, 2010, cost report.
- During FFY October 1, 2007 — September 30, 2008: The hospital does not have a cost report. The hospital enters data from the October 1, 2009 — September 30, 2010, cost report.

Fiscal Year	Total Discharges
October 1, 2010 — September 30, 2011	5,000
October 1, 2009 — September 30, 2010	1,000
October 1, 2008 — September 30, 2009	1,000
October 1, 2007 — September 30, 2008	1,000

Topic #12097

Members Who May Be Counted When Determining Patient Volume

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

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

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

Topic #12163

Patient Volume

Acute care and CAHs (critical access hospitals) must have an eligible member patient volume of at least 10 percent of their total patient volume to be eligible for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. Children's hospitals do not have any patient volume requirements. The formula that the Wisconsin Medicaid EHR Incentive Program will be using to determine the patient volume threshold is:

Eligible Member Discharges (in state) + Out-of-State Medicaid Discharges / Total Discharges All Lines of Business.

An eligible member patient encounter is defined as:

- Services rendered to an eligible member per inpatient discharges where Medicaid paid for part or all of the service.
- Services rendered to an eligible member per inpatient discharge where Medicaid paid for all or part of his or her premiums, copayments, and/or cost-sharing.

- Services rendered to an eligible member in an emergency department on any one day where Medicaid paid for part or all of the service.
- Services rendered to an eligible member in an emergency department on any one day where Medicaid paid for all or part of his or her premiums, copayments, and/or cost-sharing.

The Wisconsin Medicaid EHR Incentive Program only considers services provided to eligible members that are reimbursed with funding directly from Medicaid (Title XIX) as a patient encounter. Eligible Hospitals may be unable to determine where funding for eligible members comes from, so the Wisconsin Medicaid EHR Incentive Program will calculate the patient volume for hospitals based on claims discharge data submitted to ForwardHealth for eligible members and the total discharge data Wisconsin hospitals provide quarterly to the Wisconsin Hospital Association Information Center, LLC, pursuant to ch. 153, Wis. Stats.

The Wisconsin Medicaid EHR Incentive Program will analyze a Wisconsin hospital's patient volume on a quarterly basis and communicate qualification under patient volume requirements and the FFY quarter the hospital qualified. The Wisconsin Medicaid EHR Incentive Program will calculate eligible member patient volume for all hospitals for the first quarter of each FFY. Only those hospitals that do not meet the eligible member patient volume threshold in the first quarter will continue to have their patient volume analyzed for additional quarters of the year.

If an Eligible Hospital has met eligible member patient volume requirements, Eligible Hospitals will need to complete the Wisconsin Medicaid EHR Incentive Program application by entering the following information in this section of the application:

1. The hospital will need to enter the start date of the FFY quarter during which eligible member patient volume requirements were met (October 1, January 1, April 1, or July 1).
2. Enter in a "1" in the space labeled "Medicaid Discharges (in state Numerator)," enter a "0" into the space labeled "Other Medicaid Discharges (other Numerator)," and enter a "1" into the space labeled "Total Discharges: All Lines of Business (Denominator)."

Eligible member patient volume requirements are not applicable to children's hospitals.

Registration and Applying

Topic #12160

Applying for the Wisconsin Medicaid EHR Incentive Program

A secure Provider account on the ForwardHealth Portal is required to apply for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. All applications must be completed via a secure Provider account on the Portal. There is a link on the homepage of the secure Provider Portal in the "Quick Links" area called the "Wisconsin Medicaid EHR Incentive Program" that will take Eligible Hospitals to the application.

A clerk role, "EHR Incentive," is available in the secure Provider area of the ForwardHealth Portal. The Portal Administrator for the account or an assigned clerk that has been assigned the "EHR Incentive" role may access and/or complete the Wisconsin Medicaid EHR Incentive Program application. The Portal Administrator or assigned clerk should then access the link "Wisconsin Medicaid EHR Incentive Program" to begin the application process.

Topic #15017

Eligible Hospitals Must Submit Cost Reports

Eligible Hospitals applying for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program are required to submit relevant sections of the Medicare Cost Reports used to complete the application. Beginning in Program Year 2013, Eligible Hospitals will be required to attach all relevant Medicare Cost Report sections before submitting their Wisconsin Medicaid EHR Incentive Program application. Eligible Hospitals will receive an email from the Wisconsin Medicaid EHR Incentive Program with instructions for submitting Medicare Cost Reports for previous Program Years. The Wisconsin Medicaid EHR Incentive Program will not process future year applications for Eligible Hospitals that have not submitted Medicare Cost reports for previous Program Years.

Topic #12159

Registration for the EHR Incentive Program

All Eligible Hospitals are required to first register on the R&A (Medicare and Medicaid Electronic Health Record Incentive Program Registration and Attestation System) Web site. Eligible Hospitals may register as one of the following:

- Medicaid only.
- Medicare only.
- Medicare and Medicaid (except children's hospitals).

Note: Some Eligible Hospitals may have more than one NPI (National Provider Identifier) on file with Wisconsin Medicaid or with other payers. When registering for a Wisconsin Medicaid EHR Incentive Payment on the R&A, Wisconsin hospitals must register under the same NPI used to enroll the hospital in Wisconsin Medicaid, not an individual business unit or subpart.

Eligible Hospitals should note that if they plan to participate in both the Medicare and Medicaid EHR (Electronic Health Record) Incentive Programs, they should register with CMS (Centers for Medicare and Medicaid Services) for both programs. A step-

by-step walkthrough of the R&A registration process for Eligible Hospitals is available for download online.

After an Eligible Hospital successfully registers on the R&A, CMS will process the registration and send the file to the Wisconsin Medicaid EHR Incentive Program. After receipt of the file, the Wisconsin Medicaid EHR Incentive Program will enter all relevant information into the ForwardHealth system. Eligible Hospitals must wait two full business days before beginning the application for the Wisconsin Medicaid EHR Incentive Program to allow for this process.

Topic #12161

Required Information When Starting the Wisconsin Medicaid EHR Incentive Program Application

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

Before applying for the Wisconsin Medicaid EHR Incentive Program on the ForwardHealth Portal, Eligible Hospitals will need the following:

1. Information submitted to the CMS (Centers for Medicare and Medicaid Services) EHR Incentive Program R&A (Registration and Attestation System). Eligible Hospitals will need to confirm this information during the initial application phases.
2. Contact name, telephone number, and e-mail address of the preparer of the Eligible Hospital's application.
3. Whether or not the Eligible Hospital applying to the Wisconsin Medicaid EHR Incentive Program has any sanctions or pending sanctions with the Medicare or Medicaid programs, and is licensed to practice in all states in which services are rendered.
4. The CMS EHR certification ID that can be obtained from the ONC's (Office of the National Coordinator for Health Information Technology) Certified Health IT Product List Web site.
5. The start date of the hospital's FFY (federal fiscal year) quarter the Eligible Hospital is planning on using as their start date for the patient volume attestation period.
6. Total eligible member discharges for the selected patient volume period.
7. Total discharges for all lines of business; this number is the denominator of the patient volume equation.
8. Hospital Payment Calculation Data.
9. If solely participating in the Wisconsin Medicaid EHR Incentive Program, information to attest to either adopting, implementing, or upgrading certified EHR technologies. Hospitals not also participating in the Medicare EHR Incentive Program will not be able to attest to the "meaningful use."

Topic #12162

Reviewing, Confirming, and Submitting the Application

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

Final submission will require an electronic signature by providing the authorized preparer's initials, the hospital's NPI (National Provider Identifier), and the hospital's federal TIN (tax identification number). The preparer will also need to electronically sign the application before submission. Once the application has been submitted, an e-mail notification will be sent to notify the Eligible Hospital of the status of their application. After an application is approved, Eligible Hospitals can expect payments within 45 calendar days.

Resources for EHR Incentive Program

Topic #12138

Provider Services

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

Topic #12139

User Guide

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

Topic #12140

Web Sites

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

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

Managed Care

5

Archive Date:01/02/2013

Managed Care:Claims

Topic #385

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 (health maintenance organization) or SSI (Supplemental Security Income) 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 (F-12022 (03/09)) 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.

Topic #384

Appeals to HMOs and SSI HMOs

Providers are required to first file an appeal directly with the BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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.

Topic #1391

BadgerCare Plus or Medicaid Managed Care Coverage

For members enrolled in a BadgerCare Plus or Medicaid managed care program, the contract between the managed care program and Medicaid-enrolled provider establishes all conditions of payment and PA (prior authorization) for hospital services. Claims submitted to ForwardHealth for services covered by a managed care program are denied.

If a member is fee-for-service on his or her date of admission, but is enrolled in a BadgerCare Plus or Medicaid HMO before discharge, submit the entire inpatient claim to BadgerCare Plus fee-for-service as an extraordinary claim.

Submit extraordinary claims to:

ForwardHealth
Extraordinary Claims
313 Blettner Blvd
Madison WI 53784

If an enrollee is in a BadgerCare Plus or Medicaid HMO at the time of admittance and is disenrolled during the hospital stay, this is not an extraordinary claim. Submit the entire inpatient claim to the member's HMO.

Refer to the Managed Care Guide for information about managed care program noncovered services, emergency services, and hospitalizations.

Topic #386

Claims Submission

BadgerCare Plus HMOs (health maintenance organizations) and Medicaid SSI (Supplemental Security Income) 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.

Topic #387

Extraordinary Claims

Extraordinary claims are BadgerCare Plus or Medicaid claims for a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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. For the physician claims associated with the inpatient hospital stay, the provider is required to include the date of admittance and date of discharge in Element 18 of the paper 1500 Health Insurance Claim Form.
- 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

Topic #388

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 (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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.

Topic #389

Provider Appeals

When a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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 HMO 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

Topic #390

Covered Services

HMOs

HMOs (health maintenance organizations) are required to provide at least the same benefits as those provided under fee-for-service arrangements. Although ForwardHealth requires contracted HMOs and Medicaid SSI (Supplemental Security Income) 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.

Topic #391

Noncovered Services

The following are not covered by BadgerCare Plus HMOs (health maintenance organizations) or Medicaid SSI (Supplemental Security Income) HMOs but are provided to enrollees on a fee-for-service basis provided the member's fee-for-service plan covers the service:

- CRS (Community Recovery Services).
- CSP (Community Support Program) benefits.
- Crisis intervention services.
- Environmental lead inspections.
- CCC (child care coordination) services.
- Pharmacy services and diabetic supplies.
- PNCC (prenatal care coordination) services.
- Provider-administered drugs, including all "J" codes, drug-related "Q" codes, and a limited number of related administration codes.
- SBS (school-based services).
- Targeted case management services.
- NEMT (non-emergency medical transportation) services for most Wisconsin Medicaid and BadgerCare Plus members. Wisconsin Medicaid and BadgerCare Plus members who are enrolled in an HMO in Milwaukee, Waukesha, Washington, Ozaukee, Kenosha, and Racine counties receive NEMT services from their respective HMOs.
- DOT (directly observed therapy) and monitoring for TB-Only (Tuberculosis-Only Related Services).

Topic #13877

Striving to Quit Initiative — First Breath

Background Information

According to the CDC (Centers for Disease Control and Prevention), almost one million individuals in Wisconsin smoke every day. While the smoking rate for adults overall in the state is about 20 percent, the rate is higher — about 33 percent — for BadgerCare Plus members. Wisconsin Medicaid has received a five-year $9.2 million grant from the CMS (Centers for Medicare and Medicaid Services) to help BadgerCare Plus members enrolled in participating HMOs (health maintenance organizations) to quit smoking through the Striving to Quit initiative. Striving to Quit includes the following separate, evidence-based programs:

- Wisconsin Tobacco Quit Line (i.e., Quit Line), which offers telephone counseling to eligible members who smoke.
- First Breath, which targets eligible pregnant women who smoke by connecting them to trained tobacco cessation counselors for face-to-face tobacco cessation counseling.

First Breath

The First Breath program offers eligible pregnant women who smoke (or who have quit smoking in the last six months) face-to-face tobacco cessation counseling during their prenatal care visits and up to five face-to-face counseling visits plus additional telephone calls for support during the postpartum phase. To participate in the First Breath program, members may be referred to First Breath by their prenatal care provider or may independently call First Breath without a referral at (800) 448-5148. Members who participate in First Breath via Striving to Quit may be eligible to receive financial incentives of up to $160.00 for participation in treatment and for quitting smoking.

Enrollment Criteria

To be eligible to receive enhanced services from the First Breath program via Striving to Quit, BadgerCare Plus members must meet the following criteria:

- Be enrolled in the BadgerCare Plus Standard Plan or the BadgerCare Plus Benchmark Plan.
- Be a pregnant smoker.
- Express an interest in quitting smoking.
- Be enrolled in one of the following HMOs:
    - Children's Community Health Plan.
    - CommunityConnect HealthPlan.
    - Managed Health Services.
    - MercyCare Health Plans.
    - Molina Health Care.
    - Network Health Plan.
    - Physicians Plus Insurance Corporation.
    - Unity Health Plans Insurance Corporation.
- Reside in one of the following counties:
    - Dane.
    - Kenosha.
    - Milwaukee.
    - Racine.
    - Rock.

Covered Services

The following services are covered by Striving to Quit via First Breath:

- Up to 10 one-on-one counseling sessions during regular prenatal care appointments by First Breath providers.
- Five one-on-one counseling sessions with a trained First Breath Health Educator following delivery.
- Up to six telephone calls with the First Breath Health Educator following delivery.

Provider Responsibilities

Providers are responsible for screening pregnant BadgerCare Plus HMO members for smoking and enrolling them in the First Breath program or referring members to the First Breath program.

Clinics that currently provide First Breath services are responsible for the following:

- Screening for smoking and enrolling members in First Breath.
- Encouraging members to enroll in Striving to Quit.
- Providing regular First Breath counseling during prenatal care visits.
- Completing First Breath data forms and submitting the forms via fax to (608) 251-4136 or mail to the following address:

  Wisconsin Women's Health Foundation
  2503 Todd Dr
  Madison WI 53713

Clinics that do not currently provide First Breath smoking cessation services should refer members to First Breath.

Screening and Making Referrals

For clinics that currently provide First Breath services, there are no changes to current procedures.

The following language is suggested for providers to use to encourage members to enroll in First Breath:

> One of the benefits of enrolling in First Breath now is that you may be eligible to participate in a stop smoking study that provides free counseling services to help you quit and will pay you for taking part in certain activities. You can learn more about the program when someone from the First Breath office calls you or when you call them.

Clinics that do not currently provide First Breath services should encourage pregnant BadgerCare Plus members to seek help to quit by using the above language. Clinic staff or the member may call the First Breath program at (800) 448-5148, extension 112, for help in finding a First Breath provider in the member's area. Members may also visit the First Breath Web site to locate a First Breath provider.

Becoming a First Breath Site

Clinics not currently providing First Breath services may become First Breath sites by calling the First Breath Coordinator at (800) 448-5148, extension 112, or by visiting the First Breath Web site. Providers will need to complete four hours of training to provide First Breath services. Training is free and provided by First Breath coordinators on site. Becoming a First Breath site allows all pregnant BadgerCare Plus and Medicaid members to be served during their regular prenatal care visits.

After becoming a First Breath site, clinics will need to do the following:

- Provide evidence-based cessation counseling during regular prenatal care.
- Complete enrollment and other data forms.
- Distribute small, non-cash gifts supplied by the First Breath program.

For More Information

For more information about Striving to Quit, providers should contact their HMO representative, visit the ForwardHealth Portal, or e-mail Striving to Quit at *dhsstqinfo@wisconsin.gov*.

For more information or for technical assistance questions regarding the Quit Line, providers may visit the UW-CTRI (University

of Wisconsin Center for Tobacco Research and Intervention) Web site.

For more information or for technical assistance questions regarding First Breath, providers may call First Breath at (800) 448-5148, extension 112, or visit the First Breath Web site.

Topic #13857

Striving to Quit Initiative — Wisconsin Tobacco Quit Line

Background Information

According to the CDC (Centers for Disease Control and Prevention), almost one million individuals in Wisconsin smoke every day. While the smoking rate for adults overall in the state is about 20 percent, the rate is higher — about 33 percent — for BadgerCare Plus members. Wisconsin Medicaid has received a five-year $9.2 million grant from the CMS (Centers for Medicare and Medicaid Services) to help BadgerCare Plus members enrolled in participating HMOs (health maintenance organizations) to quit smoking through the Striving to Quit initiative. Striving to Quit includes the following separate, evidence-based programs:

- Wisconsin Tobacco Quit Line (i.e., Quit Line), which offers telephone counseling to eligible members who smoke.
- First Breath, which targets eligible pregnant women who smoke by connecting them to trained tobacco cessation counselors for face-to-face tobacco cessation counseling.

Wisconsin Tobacco Quit Line

Striving to Quit offers eligible members who smoke enhanced tobacco cessation treatment from the Quit Line. Members who participate in Striving to Quit qualify for at least five smoking cessation counseling calls from the Quit Line and appropriate tobacco cessation medications covered by Wisconsin Medicaid. To participate in Striving to Quit, members may be referred to the Quit Line by their provider or may independently call the Quit Line without a referral at (800) QUIT-NOW (784-8669).

Striving to Quit members using the Quit Line may be eligible to receive financial incentives of up to $120.00 for participation in treatment and for quitting smoking. Striving to Quit requires members who participate in Quit Line treatment services to take a biochemical test to confirm smoking status at initial enrollment, six months post-enrollment, and 12 months after enrollment in the initiative.

Enrollment Criteria

To be eligible to receive enhanced services from the Quit Line via Striving to Quit, members must meet the following criteria:

- Be enrolled in BadgerCare Plus Standard Plan or BadgerCare Plus Benchmark Plan.
- Be 18 years of age and older.
- Be a smoker and express an interest in quitting smoking.
- Be enrolled in one of the following HMOs:
    - Children's Community Health Plan.
    - Compcare.
    - Group Health Cooperative of Eau Claire.
    - Managed Health Services.
    - MercyCare Health Plans.
    - Molina Health Care.
    - Network Health Plan.
    - Physicians Plus Insurance Corporation.

- UnitedHealthcare Community Plan.
- Unity Health Plans Insurance Corporation.
- Reside in one of the following counties:
    - Dodge.
    - Fond du Lac.
    - Jefferson.
    - Sheboygan.
    - Calumet.
    - Columbia.
    - Door.
    - Florence.
    - Grant.
    - Green.
    - Iowa.
    - Kewaunee.
    - Lafayette.
    - Manitowoc.
    - Marinette.
    - Menominee.
    - Oconto.
    - Rock.
    - Sauk.
    - Walworth.
    - Waupaca.
    - Brown.
    - Dane.
    - Outagamie.
    - Winnebago.

Covered Drugs and Services

The following drugs and services are covered by Striving to Quit or Medicaid:

- Up to five cessation counseling calls to the Quit Line plus additional calls initiated by the member are covered by Striving to Quit.
- Tobacco cessation medications and biochemical testing to confirm smoking status are covered by Medicaid.

Provider Responsibilities

For members seeking Striving to Quit services from the Quit Line, providers are responsible for the following:

- Screening for smoking and referring potentially eligible members who smoke to the Quit Line.
- Conducting biochemical tests (i.e., urine cotinine tests).
- Writing prescriptions for tobacco cessation drugs for members, as appropriate.
- Working with the Quit Line, completing Striving to Quit referral forms for member referrals, writing tobacco cessation prescriptions, and faxing biochemical test results and forms to the Quit Line.
- Identifying one or two key staff members in a clinic or practice who will serve as points of contact for Striving to Quit and assist with coordinating the biochemical tests and other tasks as needed.

Screening and Making Referrals

The following language is suggested for providers to use to encourage members who smoke to agree to a referral or to call the

Quit Line themselves:

> One of the benefits of calling the Quit Line now is that you may be eligible to participate in a stop smoking study that provides free counseling services to help you quit and will pay you for taking part in certain activities. I would be happy to make a referral for you. If you are interested, all we need to do is a simple urine test to confirm that you smoke. After I send the paperwork, someone from the Quit Line will call you to tell you more about the study or you can call them directly at the number on the card. If you do not want to be in the study, you may still get some services from the Quit Line.

Providers should ask HMO members living in targeted counties if they may refer the member to the Quit Line. If a member is referred to the Quit Line, providers should submit a Striving to Quit Referral form signed by the member to the Quit Line via fax at (877) 554-6643. Striving to Quit Referral forms are available on the UW-CTRI's (University of Wisconsin Center for Tobacco Research and Intervention) Striving to Quit Web site or on the ForwardHealth Portal. A representative from the Quit Line will call the member within three business days to begin the enrollment process.

Outreach Specialists for the UW-CTRI will provide technical assistance to clinics and providers about how to make Striving to Quit referrals. A short training video about Striving to Quit procedures is available on UW-CTRI's Web site. A link to the training video is also on the Portal.

Biochemical Testing

As part of Striving to Quit, HMO members are required to have a urine cotinine test to confirm smoking status. This test should be conducted by providers in the member's HMO network using NicCheck® I testing strips. NicCheck® I testing strips (item MA-500-001) may be ordered online or by calling (888) 882-7739.

Urine cotinine test results should be faxed to the Quit Line at (877) 554-6643. Claims for urine cotinine testing should be submitted to the member's HMO.

BadgerCare Plus members may be tested on a walk-in basis at any participating clinic in the member's HMO network. Members who need assistance finding a participating clinic should contact their HMO.

Prescriptions

For HMO members identified as smokers who express an interest in quitting and agree to a referral to the Quit Line, providers should discuss the use of tobacco cessation medications. Research indicates that the use of tobacco cessation medications in combination with evidence-based counseling almost doubles the likelihood of a successful quit attempt. The following types of tobacco cessation medications are covered by Wisconsin Medicaid for BadgerCare Plus members:

- OTC (over-the-counter) nicotine gum and patches.
- Legend products (i.e., bupropion SR, Chantix, Nicotrol spray).

Providers may use the Drug Search Tool to determine the most current covered drugs. Providers may also refer to the benefit plan-specific product lists for the most current list of covered drugs.

An allowable diagnosis code must be indicated on claims for covered tobacco cessation medications. Tobacco cessation medications are not covered for uses outside the allowable diagnosis code.

If tobacco cessation medications are appropriate for members, prescriptions for tobacco cessation medications should be sent to the member's pharmacy. On the Striving to Quit Referral form sent to the Quit Line, the tobacco cessation medication prescription box should be checked either yes or no.

For HMO members who independently call the Quit Line and are enrolled in Striving to Quit, staff at the Quit Line will provide a suggested prescription to a provider within the member's HMO network. The provider will determine the adequacy of the

prescription and approve as appropriate. The provider is required to send the following:

- The prescription to the pharmacy where it will be filled (e-prescribing is preferred).
- The approval or disapproval of the prescription to the Quit Line on the Striving to Quit Referral form via fax at (877) 554-6643.

For More Information

For more information about Striving to Quit, providers should contact their HMO representative, visit the Portal, or e-mail Striving to Quit at *dhsstqinfo@wisconsin.gov*.

For more information or for technical assistance questions regarding the Quit Line, providers may visit the UW-CTRI (University of Wisconsin Center for Tobacco Research and Intervention) Web site.

Enrollment

Topic #392

Disenrollment and Exemptions

In some situations, a member may be exempt from enrolling in a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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 (Department of Health Services) and the HMO or SSI HMO provide more detail on the exemption and disenrollment requirements.

Topic #393

Enrollee Grievances

Enrollees have the right to file grievances about services or benefits provided by a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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 (Department of Health Services) and the HMO or SSI HMO describes the responsibilities of the HMO or SSI HMO and the DHS regarding enrollee grievances.

Topic #397

Enrollment Eligibility

BadgerCare Plus HMOs

Members enrolled in the BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, and the BadgerCare Plus Core Plan are eligible for enrollment in a BadgerCare Plus HMO (health maintenance organization).

An individual who receives the TB-Only (Tuberculosis-Related Services-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 (Enrollment Verification System) or the ForwardHealth Portal.

SSI HMOs

Members of the following subprograms are eligible for enrollment in a Medicaid SSI (Supplemental Security Income) 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 (managed care organization).

Topic #394

Enrollment Periods

HMOs

Members are sent enrollment packets that explain the BadgerCare Plus HMOs (health maintenance organizations) 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 (Supplemental Security Income) HMO's enrollment process and provide contact 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.

Topic #395

Enrollment Specialist

The Enrollment Specialist provides objective enrollment, education, outreach, and advocacy services to BadgerCare Plus HMO (health maintenance organization) and Medicaid SSI (Supplemental Security Income) 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.

Topic #398

Member Enrollment

HMOs

BadgerCare Plus HMO (health maintenance organization) 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 (Supplemental Security Income) 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.

Topic #396

Ombudsman Program

The Ombudsmen, or Ombuds, are resources for enrollees who have questions or concerns about their BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO. Ombuds provide advocacy and assistance to help enrollees understand their rights and responsibilities in the grievance and appeal process.

Ombuds can be contacted at the following address:

BadgerCare Plus HMO/Medicaid SSI HMO Ombudsmen
PO Box 6470
Madison WI 53716-0470

Topic #399

Release of Billing or Medical Information

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

Managed Care Information

Topic #401

BadgerCare Plus HMO Program

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

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

Topic #405

Managed Care

Managed Care refers to the BadgerCare Plus HMO (health maintenance organization) program, the Medicaid SSI (Supplemental Security Income) 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.

Topic #402

Managed Care Contracts

The contract between the DHS (Department of Health Services) and the BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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.

Topic #404

SSI HMO Program

Medicaid SSI (Supplemental Security Income) HMOs (health maintenance organizations) 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 (prior authorization) 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.

Topic #403

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 (Program of All-Inclusive Care for the Elderly), 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

Topic #400

Prior Authorization Procedures

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

Provider Information

Topic #406

Copayments

Providers cannot charge Medicaid SSI (Supplemental Security Income) HMO (health maintenance organization) 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.

Topic #407

Emergencies

Non-network providers may provide services to BadgerCare Plus HMO (health maintenance organization) and Medicaid SSI (Supplemental Security Income) HMO enrollees in an emergency without authorization or in urgent situations when authorized by the HMO or SSI HMO. The contract between the DHS (Department of Health Services) 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.

Topic #408

Non-network Providers

Providers who do not have a contract with the enrollee's BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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 (Department of Health Services) 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.

Topic #409

Out-of-Area Care

BadgerCare Plus HMOs (health maintenance organizations) and Medicaid SSI (Supplemental Security Income) 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.

Topic #410

Provider Participation

Providers interested in participating in a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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.

Topic #411

Referrals

Non-network providers may at times provide services to BadgerCare Plus HMO (health maintenance organization) and Medicaid SSI (Supplemental Security Income) 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.

Topic #412

Services Not Provided by HMOs or SSI HMOs

If an enrollee's BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO benefit package does not include a covered service, such as chiropractic or dental services, any Medicaid-enrolled provider may provide the service to the enrollee and submit claims to fee-for-service.

Member Information

6

Archive Date:01/02/2013

Member Information:Birth to 3 Program

Topic #792

Administration and Regulations

In Wisconsin, Birth to 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 (Department of Health Services) monitors, provides technical assistance, and offers other services to county Birth to 3 agencies.

The enabling federal legislation for the Birth to 3 Program is 34 CFR Part 303. The enabling state legislation is s. 51.44, Wis. Stats., and the regulations are found in DHS 90, Wis. Admin. Code.

Providers may contact the appropriate county Birth to 3 agency for more information.

Topic #790

Enrollment Criteria

A child from birth up to (but not including) age 3 is eligible for Birth to 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 Birth to 3 information because many children enrolled in the Birth to 3 Program are also BadgerCare Plus members.

Topic #791

Individualized Family Service Plan

A Birth to 3 member receives an IFSP (Individualized Family Service Plan) 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 Birth to 3 services must be identified in the child's IFSP.

Topic #788

Requirements for Providers

Title 34 CFR Part 303 for Birth to 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 Birth to 3 services. These children must be referred to the appropriate county Birth to 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 Birth to 3 program for evaluation. (Providers are encouraged to explain the need for the Birth to 3 referral to the child's parents or guardians.)
- Cooperate and participate with Birth to 3 service coordination as indicated in the child's IFSP (Individualized Family Services Plan). Birth to 3 services must be provided by providers who are employed by, or under agreement with, a Birth to 3 agency to provide Birth to 3 services.
- Deliver Birth to 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 enrollment as a therapy group to be reimbursed for these therapy services.)
- Assist parents or guardians of children receiving Birth to 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.

Topic #789

Services

The Birth to 3 Program covers the following types of services when they are included in the child's IFSP (Individualized Family Services Plan):

- Evaluation and assessment.
- Special instruction.
- OT (occupational therapy).
- PT (physical therapy).
- SLP (speech and language pathology).
- 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

Topic #785

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 (prior authorization) 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).

Topic #9297

BadgerCare Plus Basic Plan

The BadgerCare Plus Basic Plan is a self-funded plan that focuses on providing BadgerCare Plus Core Plan waitlist members with access to vital, cost-effective primary and preventive care. This option will allow members to have some minimal form of coverage until space becomes available in the Core Plan and will help prevent bankruptcy due to excessive medical debt.

Member participation or non-participation in the Basic Plan does not affect an individual's status on the Core Plan waitlist.

Services for the Basic Plan are covered under fee-for-service. Basic Plan members will not be enrolled in state-contracted HMOs (health maintenance organizations).

As of March 19, 2011, new enrollment into the Basic Plan ended. The Basic Plan will continue for members already enrolled in the Basic Plan.

Conditions That End Member Enrollment in the Basic Plan

A member's enrollment in the Basic Plan will end if the member:

- Becomes eligible for Medicare, Medicaid, the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, or the Core Plan.
- Becomes incarcerated or becomes institutionalized in an IMD (institution for mental disease).
- Becomes pregnant. (*Note:* A Basic Plan member who becomes pregnant should be referred to Member Services for more information about enrollment in the Standard Plan or the Benchmark Plan.)
- No longer resides in the state of Wisconsin.
- Obtains health insurance coverage.
- Turns 65 years of age.
- Fails to pay the monthly premium.

Note: Enrollment in the Basic Plan does not end if the member's income increases.

Providers are reminded that the Basic Plan does not cover obstetrical services or delivery services.

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.

Basic Plan Member Fact Sheets

Fact sheets providing additional member information about the Basic Plan are available.

Enrollment Certification Period for Basic Plan Members

A member's enrollment will begin on the first of the month and will continue through the end of the 12th month. For example, if the individual's enrollment in the Basic Plan begins on July 1, 2010, the enrollment certification period will continue through June 30, 2011, unless conditions occur that end enrollment.

Premium payments are due on the fifth of each month, prior to the month of coverage. Members who fail to pay the monthly premium will have their benefits terminated and will also be subject to a 12-month restrictive re-enrollment period.

Basic Plan Members Enrolled in Wisconsin Chronic Disease Program

For Basic Plan members who are also enrolled in WCDP (Wisconsin Chronic Disease Program), providers should submit claims for all covered services to the Basic Plan first and then to WCDP. For pharmacy services, if both programs deny the pharmacy claim, providers should submit the claim to BadgerRx Gold.

Basic Plan Members and HIRSP Coverage

Basic Plan members may also be enrolled in the HIRSP (Health Insurance Risk-Sharing Plan) as long as the member meets the eligibility requirements for both the Basic Plan and HIRSP. For Basic Plan members who are also enrolled in HIRSP, providers should submit claims for all Basic Plan covered services to HIRSP first and then to the Basic Plan.

Basic Plan members may not be enrolled in the Basic Plan and the Federal Temporary High Risk Insurance Pool. Information that

is being distributed to Core Plan members on the waitlist regarding HIRSP and the Federal Temporary High Risk Insurance Pool is available.

Alternatives to the BadgerCare Plus Basic Plan

Before enrolling in the BadgerCare Plus Basic Plan, you should consider two other insurance options available to some Wisconsin residents. Enrolling in BadgerCare Plus Basic will make you ineligible for coverage under the Federal Pool option described below.

Option 1: Health Insurance Risk-Sharing Plan (HIRSP)

You may qualify for HIRSP if:

1. You recently lost your employer-sponsored insurance coverage; or
2. You have been rejected for coverage in the private insurance market; or
3. You have HIV/AIDS; or
4. You have Medicare because of a disability.

HIRSP offers comprehensive medical and pharmacy benefits including coverage of brand name drugs and $150 of first dollar coverage on routine/preventive services. HIRSP will not cover medical services for a preexisting condition for the first six months of coverage. The preexisting condition waiting period does not apply to drug coverage. The medical services preexisting condition waiting period does not apply if you qualify for HIRSP because you have recently lost your employer-sponsored coverage.

If your annual household income is below $33,000, you may be entitled to a premium and deductible subsidy. For example, a 25 year old man with an annual income of less than $10,000 would pay $89 per month for a $2,500 deductible insurance plan.

HIRSP members can also be enrolled in the BadgerCare Plus Basic or Core Plan.

Option 2: Federal Temporary High Risk Insurance Pool

You may qualify for the new Federal Pool if:

1. You are a citizen or national of the United States, or are lawfully present;
2. You have a preexisting medical condition; and
3. You have been uninsured for at least 6 months before applying for coverage.

The Federal Pool will offer the same medical and drug benefits as HIRSP. There is no preexisting condition waiting period under the Federal Pool.

In most cases, the Federal Pool premium will be lower than the HIRSP premium.
Enrollment is expected to begin in July 2010, for coverage beginning August 1, 2010.

If you enroll in BadgerCare Plus Basic or HIRSP now, you will not be eligible for the Federal Pool. You should determine which program best serves your needs. For more information about HIRSP or the Federal Pool and your insurance options, please contact HIRSP Customer Service at 1.800.828.4777 or visit *www.hirsp.org*

Topic #5557

BadgerCare Plus Core Plan

The BadgerCare Plus Core Plan covers basic health care services including primary care, preventive care, certain generic and OTC (over-the-counter) drugs, and a limited number of brand name drugs.

Applicant Enrollment Requirements

An applicant must meet the following enrollment requirements in order to qualify for the Core Plan:

- Is a Wisconsin resident.
- Is a United States citizen or legal immigrant.
- Is between the ages of 19 and 64.
- Does not have any children under age 19 under his or her care.
- Is not pregnant.
- Is not eligible for or enrolled in Medicaid, the BadgerCare Plus Standard Plan, or the BadgerCare Plus Benchmark Plan. This would not include benefits provided under Family Planning Only Services or those benefits provided to individuals who qualify for the TB-Only (Tuberculosis-Related Services Only) Benefit.
- Is not eligible for or enrolled in Medicare.
- Has a monthly gross income that does not exceed 200 percent of the FPL (Federal Poverty Level).
- Is not covered by health insurance currently or in the previous 12 months.
- Has not had access to employer-sponsored insurance in the previous 12 months and does not have access to employer-subsidized insurance during the month of application or any of the three months following application.

Application Process for New Members

Individuals who wish to enroll may apply for the Core Plan using the ACCESS tool online or via the ESC (Enrollment Services Center). A pre-screening tool will help determine which individuals may be eligible to enroll in the Core Plan. Applications for Core Plan members will be processed centrally by the ESC, not by county agencies.

To complete the application process, applicants must meet the following requirements:

- Complete a Health Survey.
- Pay a non-refundable, annual processing fee of $60.00 per individual or per couple for married couples. The fee will be waived for homeless individuals. There are no monthly premiums.

Medicaid-enrolled providers cannot pay the $60.00 application processing fee on behalf of Core Plan applicants. An offer by a Medicaid-enrolled provider to pay a fee on behalf of a prospective Medicaid member may violate federal laws against kickbacks. These laws are federal criminal statutes that are interpreted and enforced by federal agencies such as the United States DOJ (Department of Justice) and the Department of HHS (Health and Human Services') OIG (Office of the Inspector General).

Conditions That End Member Enrollment in the Core Plan

A member's enrollment will end if the member:

- Becomes eligible for Medicare, Medicaid, the Standard Plan, or the Benchmark Plan.
- Becomes incarcerated or institutionalized in an IMD (institution for mental disease).
- Becomes pregnant.
- No longer resides in the state of Wisconsin.
- Obtains health insurance coverage.
- Turns 65 years of age.

Providers are reminded that the Core Plan does not cover obstetrical services, including the delivery of a child or children. A Core Plan member who becomes pregnant should be referred to the ESC for more information about enrollment in the Standard Plan or the Benchmark Plan.

Enrollment Certification Period for Core Plan Members

Once determined eligible for enrollment in the Core Plan, a member's enrollment will begin either on the first or 15th of the month, whichever is first, and will continue through the end of the 12th month. For example, if the individual submits all of his or her application materials, including the application fee, by September 17, 2009, and the DHS (Department of Health Services) reviews the application and approves it on October 6, 2009, the individual is eligible for enrollment beginning on October 15, 2009, the next possible date of enrollment. The enrollment certification period will continue through October 31, 2010.

The enrollment certification period for individuals who qualify for the Core Plan is 12 months, regardless of income changes.

Core Plan Members Enrolled in Wisconsin Chronic Disease Program

For Core Plan members who are also enrolled in WCDP (Wisconsin Chronic Disease Program), providers should submit claims for all covered services to the Core Plan first and then to WCDP. For pharmacy services, if both programs deny the pharmacy claim, providers should submit claims to BadgerRx Gold.

Core Plan Members with HIRSP Coverage

Core Plan members may also be enrolled in HIRSP (Health Insurance Risk Sharing Plan) as long as the member meets the eligibility requirements for both the Core Plan and HIRSP. For Core Plan members who are also enrolled in HIRSP, providers should submit claims for all Core Plan covered services to the Core Plan. For services not covered by the Core Plan, providers should submit claims to HIRSP. For members enrolled in the Core Plan, HIRSP is always the payer of last resort.

Note: HIRSP will only cover noncovered Core Plan services if the services are covered under the HIRSP benefit.

Topic #225

BadgerCare Plus Standard Plan and Benchmark Plan

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

Topic #6917

Benefit Plans Under BadgerCare Plus

BadgerCare Plus is comprised of four benefit plans, the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, and the BadgerCare Plus Basic Plan.

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 (Federal Poverty Level). The services covered under the Standard Plan are the same as the Wisconsin Medicaid program.

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. The services covered under the Benchmark Plan are more limited than those covered under the Wisconsin Medicaid program.

BadgerCare Plus Core Plan

The Core Plan provides adults who were previously not eligible to enroll in state and federal health care programs with access to basic health care services including primary care, preventive care, certain generic and OTC (over-the-counter) drugs, and a limited number of brand name drugs.

BadgerCare Plus Basic Plan

The Basic Plan provides Core Plan waitlist members with access to vital, cost-effective primary and preventive care. This option allows members to have some form of minimal coverage until space becomes available in the Core Plan.

Topic #230

Express Enrollment for Children and Pregnant Women

The EE (Express Enrollment) 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.

The EE for Children Benefit allows certain members through 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.

Topic #226

Family Planning Only Services

Family Planning Only Services is a limited benefit program that provides routine contraceptive-related services to low-income individuals who are at least 15 years of age who are otherwise not eligible for Wisconsin Medicaid or BadgerCare Plus. There is no upper age limit for Family Planning Only Services enrollment as long as the member is of childbearing age. Members receiving Family Planning Only Services must be receiving routine contraceptive-related services.

The goal of Family Planning Only Services is to provide members 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 Family Planning Only Services to members and encourage them to contact their certifying agency to determine their enrollment options if they are not interested in, or do not need, contraceptive services.

Members enrolled in Family Planning Only Services receive routine services to prevent or delay pregnancy and are not eligible for other services (e.g., PT (physical therapy) services, dental services). Even if a medical condition is discovered during a family planning visit, treatment for the condition is not covered under Family Planning Only Services unless the treatment is identified in the list of allowable procedure codes for Family Planning Only Services.

Members are also not eligible for certain other services that are covered under the Wisconsin Medicaid and BadgerCare Plus family planning benefit (e.g., mammograms and hysterectomies). If a medical condition, other than an STD (sexually transmitted disease), is discovered during contraceptive-related services, treatment for the medical condition is not covered under Family Planning Only Services.

Colposcopies and treatment for STDs are only covered through Family Planning Only Services 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 enrolled in Family Planning Only Services and receiving contraceptive-related services.

Family Planning Only Services 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 members about other service options and provide referrals for care not covered by Family Planning Only Services.

Temporary Enrollment for Family Planning Only Services

Members whose providers are submitting an initial Family Planning Only Services application on their behalf and who meet the enrollment criteria may receive routine contraceptive-related services immediately through TE (temporary enrollment) for Family Planning Only Services for up to two months. Services covered under the TE for Family Planning Only Services are the same as those covered under Family Planning Only Services and must be related to routine contraceptive management.

To determine enrollment for Family Planning Only Services, providers should use the income limit for 300 percent of the FPL (Federal Poverty Level).

TE for Family Planning Only Services providers may issue white paper TE for Family Planning Only Services identification cards for members to use until they receive a ForwardHealth identification card. Providers should remind members that the benefit is

temporary, despite their receiving a ForwardHealth card.

Topic #4757

ForwardHealth and ForwardHealth interChange

ForwardHealth brings together many DHS (Department of Health Services) 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 (Wisconsin Chronic Disease Program).
- WIR (Wisconsin Immunization Registry).
- Wisconsin Medicaid.
- Wisconsin Well Woman Medicaid.
- WWWP (Wisconsin Well Woman Program).

ForwardHealth interChange is supported by the state's fiscal agent, HP (Hewlett-Packard).

Topic #229

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 (Express Enrollment) for Children.
- EE for Pregnant Women.
- Family Planning Only Services, including TE (Temporary Enrollment) for Family Planning Only Services.
- QDWI (Qualified Disabled Working Individuals).
- QI-1 (Qualifying Individuals 1).
- QMB Only (Qualified Medicare Beneficiary Only).
- SLMB (Specified Low-Income Medicare Beneficiary).
- TB-Only (Tuberculosis-Related Services-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, Family Planning Only Services, 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 Family Planning Only Services and the TB-Only Benefit.

Providers are strongly encouraged to verify dates of enrollment and other coverage information using the EVS (Wisconsin's Enrollment Verification System) 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.

Topic #228

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 (Wisconsin Medical Assistance Program), MA (Medical Assistance), 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 (Supplemental Security Income).
- WWWP (Wisconsin Well Woman Program).

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 (Social Security Administration) 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 (managed care organizations).

Topic #10217

Members Enrolled in the Wisconsin Well Woman

Program and the BadgerCare Plus Basic Plan

Women may be enrolled in the WWWP (Wisconsin Well Woman Program) and the BadgerCare Plus Basic Plan at the same time. Women who are diagnosed with breast cancer or cervical cancer while enrolled in WWWP are eligible to be enrolled in WWWMA (Wisconsin Well Woman Medicaid) through the WWWP. WWWMA covers the same services as Wisconsin Medicaid; therefore, enrollment in WWWMA enables members to receive comprehensive treatment, including services not related to their diagnosis.

Once a woman is enrolled in WWWMA, she is no longer eligible for the Basic Plan.

Topic #232

Qualified Disabled Working Individual Members

QDWI (Qualified Disabled Working Individual) 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 (Federal Poverty Level).
- Be entitled to, but not necessarily enrolled in, Medicare Part A.
- Have income or assets too high to qualify for QMB-Only (Qualified Medicare Beneficiary-Only) and SLMB (Specified Low-Income Medicare Beneficiaries).

Topic #234

Qualified Medicare Beneficiary-Only Members

QMB-Only (Qualified Medicare Beneficiary-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 (Federal Poverty Level).
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Topic #235

Qualifying Individual 1 Members

QI-1 (Qualifying Individual 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 (Federal Poverty Level).
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Topic #236

Specified Low-Income Medicare Beneficiaries

SLMB (Specified Low-Income Medicare Beneficiary) 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 (Federal Poverty Level).
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Topic #262

Tuberculosis-Related Services-Only Benefit

The TB-Only (Tuberculosis-Related Services-Only) Benefit is a limited benefit category that allows individuals with TB (tuberculosis) infection or disease to receive covered TB-related outpatient services.

Topic #240

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 (Wisconsin Well Woman Program) or Family Planning Only Services, 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 WWWMA (Wisconsin Well Woman Medicaid) are reimbursed through Medicaid fee-for-service.

Members Enrolled into Wisconsin Well Woman Medicaid from Benchmark Plan or Core Plan

Women diagnosed with breast cancer or cervical cancer while enrolled in the BadgerCare Plus Benchmark Plan or BadgerCare Plus Core Plan are eligible to be enrolled in WWWMA. Wisconsin Well Woman Medicaid covers the same services as Wisconsin Medicaid and enables members to receive comprehensive treatment, including services not related to their diagnosis.

Women who are diagnosed with breast cancer, cervical cancer, or a precancerous condition of the cervix must have the diagnosis of their condition confirmed by one of the following Medicaid-enrolled providers:

- Nurse practitioners, for cervical conditions only.
- Osteopaths.
- Physicians.

Women with Medicare or other insurance that covers treatment for her cancer are not allowed to be enrolled into WWWMA.

Covered and Noncovered Services

Wisconsin Well Woman Medicaid covers the same services as Wisconsin Medicaid regardless of whether the service is related to her cancer treatment.

Reimbursement

Providers will be reimbursed for services provided to members enrolled in WWWMA at the Wisconsin Medicaid rate of reimbursement for covered services.

Copayments

There are no copayments for any Medicaid-covered service for WWWMA members who have been enrolled into WWWMA from the Benchmark or the Core Plan. Providers are required to reimburse members for any copayments members paid on or after the date of diagnosis while still enrolled in the Benchmark Plan or the Core Plan.

Enrollment Responsibilities

Topic #241

General Information

Members have certain responsibilities per DHS 104.02, Wis. Admin. Code, and the ForwardHealth Enrollment and Benefits (P-00079 (10/11)) booklet.

Topic #243

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 and Medicaid 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 (Enrollment Verification System) or the ForwardHealth Portal prior to providing each service, even if an approved PA (prior authorization) request is obtained for the service.

Topic #707

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.

Topic #269

Members Should Present Card

It is important that providers determine a member's enrollment and other insurance coverage *prior to* each DOS (date of service) 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 (durable medical equipment) 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.

Topic #244

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.

Topic #245

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

Topic #246

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 (Division of Hearings and Appeals).

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 (DHA-28 (08/09)) 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
313 Blettner Blvd
Madison WI 53784

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.

Topic #247

Freedom of Choice

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

Topic #248

General Information

Members are entitled to certain rights per DHS 103, Wis. Admin. Code.

Topic #250

Notification of Discontinued Benefits

When the DHS (Department of Health Services) 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.

Topic #252

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.

Topic #254

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 (Qualified Medicare Beneficiary-Only) members.

Identification Cards

Topic #9357

ForwardHealth Basic Plan Identification Cards

Members enrolled in the BadgerCare Plus Basic Plan will receive a ForwardHealth Basic Plan card. All identification cards include the member's name and 10-digit member identification number. The identification cards may be used to verify a member's enrollment, but possession of an identification card does not guarantee enrollment. 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.

Providers should always check enrollment for a member who presents a ForwardHealth card to verify if the member is enrolled in the Basic Plan or in one of the other ForwardHealth programs. (Providers may use the same methods of enrollment verification under the Basic Plan as they do for other ForwardHealth programs such as Medicaid. These methods include the ForwardHealth Portal, WiCall, magnetic stripe readers, and the 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response) transactions.) Members who present a ForwardHealth card or a ForwardHealth Basic Plan card may have been enrolled in a different plan since the card was issued. Providers should be careful to verify the plan in which the member is enrolled and know which services are covered under that plan.

Basic Plan members should call Member Services with questions about premiums and covered services. The ForwardHealth Basic Plan cards include the Member Services telephone number on the back.

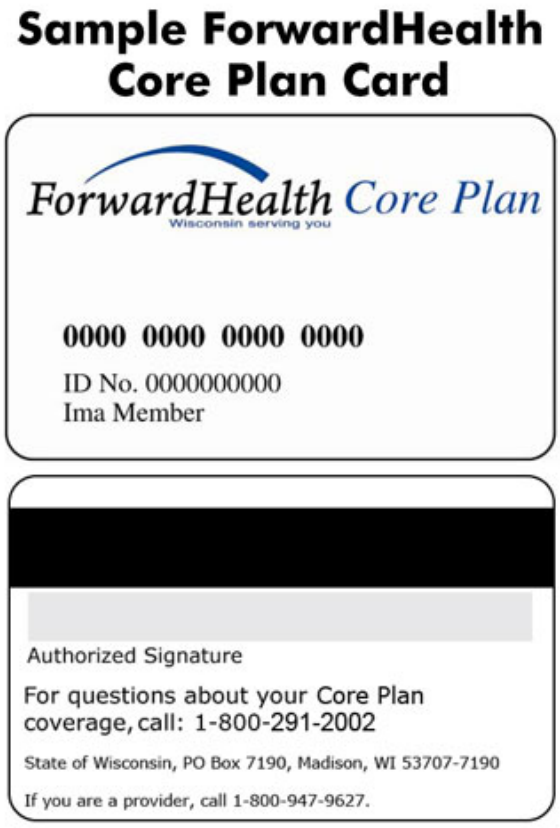
Topic #6977

ForwardHealth Core Plan Identification Cards

Members enrolled in the BadgerCare Plus Core Plan will receive a ForwardHealth Core Plan card. All identification cards include the member's name and 10-digit member identification number. The identification cards may be used to verify a member's enrollment, but possession of an identification card does not guarantee enrollment. 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.

Core Plan members should call Member Services with questions about enrollment criteria, HMO (health maintenance organization) enrollment, and covered services.

Providers should always check enrollment for a member who presents a ForwardHealth card to verify if the member is enrolled in the Core Plan or in one of the other ForwardHealth programs. Members who present a ForwardHealth card or a ForwardHealth Core Plan card may have been enrolled in a different plan since the card was issued. Providers should be careful to verify the plan in which the member is enrolled and know which services are covered under that plan.



Topic #266

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 (Enrollment Verification System).

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 (Automated Voice Response).

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 (managed care organization) 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.

Topic #268

Temporary Enrollment for Family Planning Only Services Identification Cards

Qualified providers may issue white paper TE (Temporary Enrollment) for Family Planning Only Services identification cards for members to use temporarily until they receive a ForwardHealth identification card. The identification card is included with the TE for Family Planning Only Services Application (F-10119).

The TE for Family Planning Only Services identification cards have the following message printed on them: "Temporary Identification Card for Temporary Enrollment for Family Planning Only Services." Providers should accept the white TE for Family Planning Only Services identification cards as proof of enrollment for the dates provided on the cards and are encouraged to keep a photocopy of the card.

Topic #267

Temporary Express Enrollment Cards

There are two types of temporary EE (Express Enrollment) 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 valid 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 through the online EE process. 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.

The paper application may also be used to apply for temporary ambulatory prenatal benefits for pregnant women. A beige paper identification card is attached to the last page of the application and provided to the woman after she completes the enrollment process.

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 (Enrollment Verification System) to verify enrollment for DOS (dates of service) after those printed on the card. Providers are encouraged to keep a photocopy of the card.

Sample Express Enrollment Cards

Which benefit?	Status of your benefits?
BadgerCare Plus temporary enrollment for pregnant women	You applied for BadgerCare Plus Express Enrollment on **06/26/2008**. You are temporarily enrolled in BadgerCare Plus for outpatient pregnancy-related services. Your enrollment will end on or before **07/31/2008**. To learn more, see your Rights and Responsibilities. To get regular BadgerCare Plus or Wisconsin Medicaid, you must apply online, by mail or in person: • Online at http://access.wi.gov • By mail or in person at: Dane County Job Center 1819 Aberg Ave. Madison, WI 53704 (608) 242-7400
To learn more, see your Rights and Responsibilities.	

To the Provider

The individual listed has been temporarily enrolled through BadgerCare Plus Express Enrollment in accordance with Wis. Stat. s. 49.471. This card entitles this individual to receive pregnancy related outpatient care including pharmacy services through BadgerCare Plus from any certified BadgerCare Plus provider for the period specified on this card. (See card effective dates.) For additional information, call Provider Services at (800) 947-9627 or see the All Provider Handbook.

NOTE:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services as long as other reimbursement requirements are met. All policies regarding covered services apply during the temporary enrollment period, including the prohibition against billing recipients. Refer to the All Provider Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

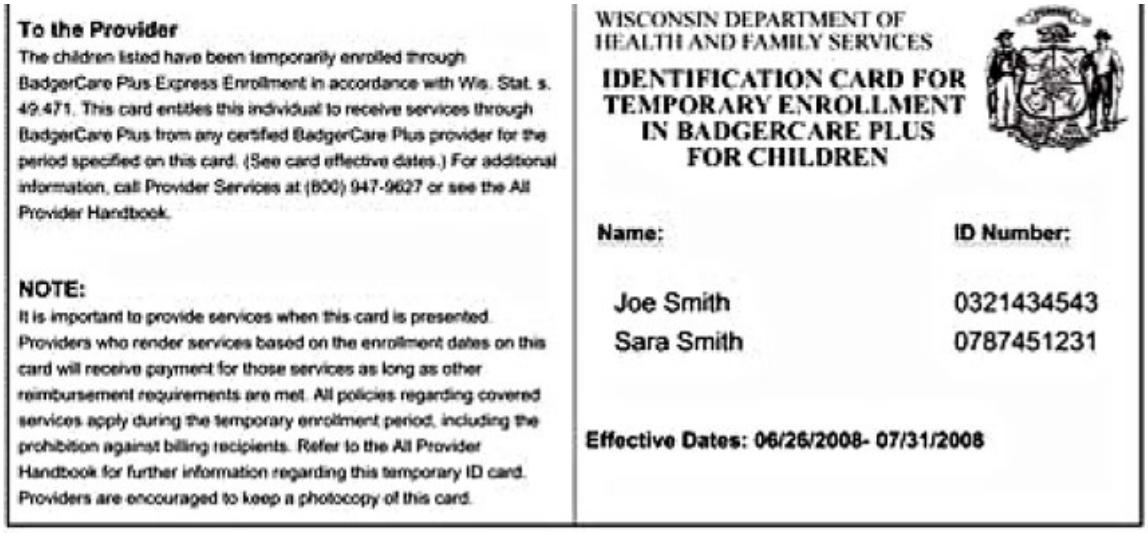
WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES

IDENTIFICATION CARD FOR TEMPORARY ENROLLMENT IN BADGERCARE PLUS FOR PREGNANT WOMEN

Name:	ID Number:
Jane Smith	0454782131

Effective Dates: 06/26/2008- 07/31/2008

Which benefit?	Status of your benefits?
BadgerCare Plus temporary enrollment for children	You applied for BadgerCare Plus Express Enrollment on **06/26/2008**. The following individual(s) is/are temporarily enrolled in BadgerCare Plus: • **Joe Smith** • **Sara Smith** This temporary enrollment will end on or before **07/31/2008**. To learn more, see your Rights and Responsibilities. In order to continue receiving BadgerCare Plus you must apply through one of the following methods: • Online at http://access.wi.gov • By mail or in person at: Dane County Job Center 1819 Aberg Ave. Madison, WI 53704 (608) 242-7400
To learn more, see your Rights and Responsibilities.	



To the Provider

The children listed have been temporarily enrolled through BadgerCare Plus Express Enrollment in accordance with Wis. Stat. s. 49.471. This card entitles this individual to receive services through BadgerCare Plus from any certified BadgerCare Plus provider for the period specified on this card. (See card effective dates.) For additional information, call Provider Services at (800) 947-9627 or see the All Provider Handbook.

NOTE:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services as long as other reimbursement requirements are met. All policies regarding covered services apply during the temporary enrollment period, including the prohibition against billing recipients. Refer to the All Provider Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES

IDENTIFICATION CARD FOR TEMPORARY ENROLLMENT IN BADGERCARE PLUS FOR CHILDREN

Name:	ID Number:
Joe Smith	0321434543
Sara Smith	0787451231

Effective Dates: 06/26/2008- 07/31/2008

Topic #1435

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.
- White plastic ForwardHealth Core Plan cards.
- White plastic ForwardHealth Basic Plan cards.
- White plastic SeniorCare cards.
- Paper printout temporary card for EE (Express Enrollment) for children.
- Paper printout temporary card for EE for pregnant women.
- Beige paper temporary card for EE for pregnant women.
- White paper TE (Temporary Enrollment) for Family Planning Only Services cards.

Misuse and Abuse of Benefits

Topic #271

Examples of Member Abuse or Misuse

Examples of member abuse or misuse are included in DHS 104.02(5), Wis. Admin. Code.

Topic #274

Pharmacy Services Lock-In Program

Overview of the Pharmacy Services Lock-In Program

The purpose of the Pharmacy Services Lock-In Program is to coordinate the provision of health care services for members who abuse or misuse Medicaid, BadgerCare Plus, or SeniorCare benefits by seeking duplicate or medically unnecessary services, particularly for controlled substances. The Pharmacy Services Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in DHS 104.02, Wis. Admin. Code.

Coordination of member health care services is intended to:

- Curb the abuse or misuse of controlled substance medications.
- Improve the quality of care for a member.
- Reduce unnecessary physician utilization.

The Pharmacy Services Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in DHS 104.02, Wis. Admin. Code. The abuse and misuse definition includes:

- Not duplicating or altering prescriptions.
- Not feigning illness, using false pretense, providing incorrect enrollment status, or providing false information to obtain service.
- Not seeking duplicate care from more than one provider for the same or similar condition.
- Not seeking medical care that is excessive or not medically necessary.

The Pharmacy Services Lock-In Program applies to members in fee-for-service as well as members enrolled in Medicaid SSI (Supplemental Security Income) HMOs (health maintenance organizations) and BadgerCare Plus HMOs. Members remain enrolled in the Pharmacy Services Lock-In Program for two years and are continuously monitored for their prescription drug usage. At the end of the two-year enrollment period, an assessment is made to determine if the member should continue enrollment in the Pharmacy Services Lock-In Program.

Members enrolled in the Pharmacy Services Lock-In Program will be locked into one pharmacy where prescriptions for restricted medications must be filled and one prescriber who will prescribe restricted medications. Restricted medications are most controlled substances, carisoprodol, and tramadol. Referrals will be required only for restricted medication services.

Fee-for-service members enrolled in the Pharmacy Services Lock-In Program may choose physicians and pharmacy providers from whom to receive prescriptions and medical services not related to restricted medications. Members enrolled in an HMO must comply with the HMO's policies regarding care that is not related to restricted medications.

Referrals of members as candidates for lock-in are received from retrospective DUR (Drug Utilization Review), physicians, pharmacists, other providers, and through automated surveillance methods. Once a referral is received, six months of pharmacy claims and diagnoses data are reviewed. A recommendation for one of the following courses of action is then made:

- No further action.
- Send an intervention letter to the physician.
- Send a warning letter to the member.
- Enroll the member in the Pharmacy Services Lock-In Program.

Medicaid, BadgerCare Plus, and SeniorCare members who are candidates for enrollment in the Pharmacy Services Lock-In Program are sent a letter of intent, which explains the restriction that will be applied, how to designate a primary prescriber and a pharmacy, and how to request a hearing if they wish to contest the decision for enrollment (i.e., due process). If a member fails to designate providers, the Pharmacy Services Lock-In Program may assign providers based on claims' history. In the letter of intent, members are also informed that access to emergency care is not restricted.

Letters of notification are sent to the member and to the lock-in primary prescriber and pharmacy. Providers may designate alternate prescribers or pharmacies for restricted medications, as appropriate. Members remain in the Pharmacy Services Lock-In Program for two years. The primary lock-in prescriber and pharmacy may make referrals for specialist care or for care that they are otherwise unable to provide (e.g., home infusion services). The member's utilization of services is reviewed prior to release from the Pharmacy Services Lock-In Program, and lock-in providers are notified of the member's release date.

Excluded Drugs

The following scheduled drugs will be excluded from monitoring by the Pharmacy Services Lock-In Program:

- Anabolic steroids.
- Barbiturates used for seizure control.
- Lyrica®.
- Provigil® and Nuvigil®.
- Weight loss drugs.

Pharmacy Services Lock-In Program Administrator

The Pharmacy Services Lock-In Program is administered by HID (Health Information Designs, Inc.). HID may be contacted by telephone at (800) 225-6998, extension 3045, by fax at (800) 881-5573, or by mail at the following address:

Pharmacy Services Lock-In Program
c/o Health Information Designs
391 Industry Dr
Auburn AL 36832

Pharmacy Services Lock-In Prescribers Are Required to Be Enrolled in Wisconsin Medicaid

To prescribe restricted medications for Pharmacy Services Lock-In Program members, prescribers are required to be enrolled in Wisconsin Medicaid. Enrollment for the Pharmacy Services Lock-In Program is not separate from enrollment in Wisconsin Medicaid.

Role of the Lock-In Prescriber and Pharmacy Provider

The Lock-In prescriber determines what restricted medications are medically necessary for the member, prescribes those

medications using his or her professional discretion, and designates an alternate prescriber if needed. If the member requires an alternate prescriber to prescribe restricted medications, the primary prescriber should complete the Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services (F-11183 (12/10)) form and return it to the Pharmacy Services Lock-In Program and to the member's HMO, if applicable.

To coordinate the provision of medications, the Lock-In prescriber may also contact the Lock-In pharmacy to give the pharmacist(s) guidelines as to which medications should be filled for the member and from whom. The primary Lock-In prescriber should also coordinate the provision of medications with any other prescribers he or she has designated for the member.

The Lock-In pharmacy fills prescriptions for restricted medications that have been written by the member's Lock-In prescriber(s) and works with the Lock-In prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The Lock-In pharmacy may fill prescriptions for medications from prescribers other than the Lock-In prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated Lock-In prescriber, the claim will be denied.

Designated Lock-In Pharmacies

The Pharmacy Services Lock-In Program pharmacy fills prescriptions for restricted medications that have been written by the member's Lock-In prescriber(s) and works with the Lock-In prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The Lock-In pharmacy may fill prescriptions for medications from prescribers other than the Lock-In prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated Lock-In prescriber, the claim will be denied.

Alternate Providers for Members Enrolled in the Pharmacy Services Lock-In Program

Members enrolled in the Pharmacy Services Lock-In Program do not have to visit their Lock-In prescriber to receive medical services unless an HMO requires a primary care visit. Members may see other providers to receive medical services; however, other providers cannot prescribe restricted medications for Pharmacy Services Lock-In Program members unless specifically designated to do so by the primary Lock-In prescriber. For example, if a member sees a cardiologist, the cardiologist may prescribe a statin for the member, but the cardiologist may not prescribe restricted medications unless he or she has been designated by the Lock-In prescriber as an alternate provider.

A referral to an alternate provider for a Pharmacy Services Lock-In Program member is necessary only when the member needs to obtain a prescription for a restricted medication from a provider other than his or her Lock-In prescriber or Lock-In pharmacy.

If the member requires alternate prescribers to prescribe restricted medications, the primary Lock-In prescriber is required to complete the Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services form. Referrals for fee-for-service members must be on file with the Pharmacy Services Lock-In Program. Referrals for HMO members must be on file with the Pharmacy Service Lock-In Program and the member's HMO.

Designated alternate prescribers are required to be enrolled in Wisconsin Medicaid.

Claims from Providers Who Are Not Designated Pharmacy Services Lock-In Providers

If the member brings a prescription for a restricted medication from a non-Lock-In prescriber to the designated Lock-In pharmacy, the pharmacy provider cannot fill the prescription.

If a pharmacy claim for a restricted medication is submitted from a provider who is not the designated Lock-In prescriber, alternate prescriber, Lock-In pharmacy, or alternate pharmacy, the claim will be denied. If a claim is denied because the

prescription is not from a designated Lock-In prescriber, the Lock-In pharmacy provider cannot dispense the drug or collect a cash payment from the member because the service is a nonreimbursable service. However, the Lock-In pharmacy provider may contact the Lock-In prescriber to request a new prescription for the drug, if appropriate.

To determine if a provider is on file with the Pharmacy Services Lock-In Program, the Lock-In pharmacy provider may do one of the following:

- Speak to the member.
- Call HID.
- Call Provider Services.
- Use the ForwardHealth Portal.

Claims are not reimbursable if the designated Lock-In prescriber, alternate Lock-In prescriber, Lock-In pharmacy, or alternate Lock-In pharmacy provider is not on file with the Pharmacy Services Lock-In Program.

Exceptions

Certain exceptions will be made regarding Pharmacy Services Lock-In Program requirements. The following are exempt from Pharmacy Services Lock-In Program requirements:

- Out-of-state providers who are not enrolled in Wisconsin Medicaid.
- Administration of drugs during an emergency room visit.

If a member enrolled in the Pharmacy Services Lock-In Program presents a prescription for a restricted medication from an emergency room visit or an out-of-state provider, the pharmacist at the Lock-In pharmacy must attempt to contact the Lock-In prescriber to verify the appropriateness of filling the prescription. If the pharmacy provider is unable to contact the Lock-In prescriber, the pharmacist should use his or her professional judgment to determine whether or not the prescription should be filled. If the prescription is filled, the claim must be submitted on paper using the Pharmacy Special Handling Request (F-13074 (07/12)) form.

The ForwardHealth emergency medication dispensing policy does not apply to the Pharmacy Services Lock-In Program. Drugs dispensed in an emergency to Pharmacy Services Lock-In Program members are nonreimbursable services except as noted above. Providers cannot collect payment from Pharmacy Services Lock-In Program members for nonreimburseable services.

For More Information

Providers may call HID with questions about the Pharmacy Services Lock-In Program. Pharmacy providers may also refer to the list of restricted medications data table or call Provider Services with questions about the following:

- Drugs that are restricted for Pharmacy Services Lock-In Program members.
- A member's enrollment in the Pharmacy Services Lock-In program.
- A member's designated Lock-In prescriber or Lock-In pharmacy.

Topic #273

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 Pharmacy Services Lock-In Program or to criminal prosecution.

Topic #275

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

Topic #276

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.

Topic #279

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 and Wisconsin Medicaid cover 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 (prior authorization) 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 enrolled 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.

Topic #552

Newborn Reporting

Hospitals, physicians, nurse practitioners, nurse midwives, and BadgerCare Plus or Medicaid HMOs may submit newborn reports to report babies born to mothers enrolled in BadgerCare Plus or Medicaid at the time of birth. Timely reporting of newborns ensures that there will be no delay in receiving important services.

Physicians, nurse practitioners, and nurse midwives should report newborns *only* if the mother is *not* enrolled in a BadgerCare Plus HMO and the birth occurs outside a hospital setting. Otherwise, the hospital *or* BadgerCare Plus HMO should report the birth. If a mother is enrolled in a BadgerCare Plus HMO but has her baby outside the HMO network, the hospital provider or HMO is responsible for reporting the birth to ForwardHealth.

Hospitals, providers, or HMOs should complete and submit *one* newborn report per newborn, depending on the enrollment status of the mother. For example, if the mother is enrolled in an HMO, the HMO *or* the hospital should report the newborn. Providers should not submit reports as long as the HMO or the hospital is reporting the newborn.

Newborns should be reported to ForwardHealth even in instances in which the baby is born alive but does not survive or if the baby is not staying with the mother after birth.

Newborn Report Submission

Providers are encouraged to submit a newborn report soon after a baby is born to avoid a delay in establishing the baby's enrollment in BadgerCare Plus or the mother's BadgerCare Plus HMO. Before completing a newborn report, providers should verify that the baby has not already been enrolled. This verification could save time and avoid the possibility of the baby having multiple records.

Providers should not use the EE (Express Enrollment) process if the mother is enrolled in BadgerCare Plus or Medicaid at the time of birth.

Providers may report the birth of a baby by submitting the Newborn Report (F-1165 (06/11)) form or submitting the information in another format as long as all information required on the Newborn Report form is provided. Required information includes the following:

- Provider's name.
- Contact name and telephone number.
- Baby's last name.
- Baby's gender.
- Baby's date of birth (in MM/DD/CCYY format).
- Indication if newborn weight is less than 1200 grams.
- Mother's full name.
- Mother's member ID (identification) number.
- Mother's full address.
- Provider representative signature.
- Date the report was completed.

Providers are required to report each baby separately.

Newborn reports may be submitted by fax to (608) 224-6318 or by mail to the following address:

ForwardHealth
PO Box 6470
Madison WI 53716

For privacy and security purposes, providers should *not* submit newborn reports via e-mail.

If incomplete information is provided or if multiple babies are listed on one newborn report, the report will be returned to the contact person indicated on the report in the manner in which it was submitted.

Newborn reports should be submitted only for babies born to women enrolled in BadgerCare Plus or Medicaid.

Reporting a Newborn's Name

Although the baby's first name may not be available at the time the newborn report is ready to be submitted, *every* effort should be made to provide the first name. The first name is important in order to prevent assigning multiple ID numbers to the same baby.

Providers are required to indicate a baby's last name on the report.

Newborn Report Procedures

Once the completed newborn report is submitted, the following procedures take place:

- A ForwardHealth ID number is assigned to the newborn if there is not an existing ID number on file.
- A ForwardHealth card is issued to the child as soon as the child's BadgerCare Plus enrollment is put on file.
- A letter is sent to the child's primary casehead, notifying him or her of the child's enrollment.

Babies Born to Mothers Not Enrolled in BadgerCare Plus or Medicaid

If a mother was not enrolled in BadgerCare Plus or Medicaid at the time of birth, providers should not report the newborn. The mother may apply for eligibility for her baby through her local county or tribal social services agency. The newborn may also be enrolled through the EE process.

If the mother was not enrolled in BadgerCare Plus or Medicaid at the time of birth, she can apply for benefits retroactively. If her dates of enrollment include the date of the baby's birth, her baby may also be able to receive retroactive and continuous enrollment for the first year of life.

Providers with questions regarding newborn enrollment or newborn reporting may call Provider Services.

Topic #277

Non-U.S. Citizens — Emergency Services

Certain non-U.S. citizens who are not qualified aliens are eligible for services only in cases of acute emergency medical conditions. Providers should use the appropriate 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 and Wisconsin Medicaid do 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-qualifying immigrants are eligible for Medicaid enrollment under the CEN (continuously eligible newborn) option. However, babies born to women with incomes over 300 percent of the FPL (Federal Poverty Level) 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 (F-1162 (02/09)) 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.

Topic #278

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.

Topic #280

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-enrolled provider for a covered service during the period of retroactive enrollment, according to DHS 104.01(11), Wis. Admin. Code. A Medicaid-enrolled 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 (prior authorization) 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 (date of service) 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 (Enrollment Verification System) (if the services provided during the period of retroactive enrollment were covered).

Topic #281

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 (date of service) 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 (F-10109 (07/08)) 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:01/02/2013

Prior Authorization:Advanced Imaging Services

Topic #10678

Prior Authorization for Advanced Imaging Services

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

Decisions

Topic #424

Approved Requests

PA (prior authorization) 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.

Topic #4724

Communicating Prior Authorization Decisions

ForwardHealth will make a decision regarding a provider's PA (prior authorization) 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.

Topic #5038

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 (prior authorization) request or amendment request via the Portal to ForwardHealth for processing.

Topic #5037

Decision Notice Letters and Returned Provider Review Letters on the Portal

Providers can view PA (prior authorization) 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.

Topic #425

Denied Requests

When a PA (prior authorization) 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 (Prior Authorization Request Form, F-11018 (07/12)), PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/12)), or PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (07/12)).
- 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.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

   Division of Hearings and Appeals
   Department of Administration
   PO Box 7875
   Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #426

Modified Requests

Modification is a change in the services originally requested on a PA (prior authorization) 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.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

   Division of Hearings and Appeals
   Department of Administration
   PO Box 7875
   Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #4737

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 (prior authorization) 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.

Topic #427

Returned Requests

A PA (prior authorization) 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 and dental models will be returned once the PA is finalized.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

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

Topic #429

Emergency Services

In emergency situations, the PA (prior authorization) 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.

Topic #430

Urgent Services

Telephone consultations with DHCAA (Division of Health Care Access and Accountability) staff regarding a prospective PA (prior authorization) 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 Quality Assurance and Appropriateness Review Section 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

Topic #4738

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. The method ForwardHealth will use to communicate decisions regarding PA (prior authorization) amendment requests will depend on how the *PA request* was originally submitted (not how the amendment request was submitted) and whether the provider has a ForwardHealth Portal account:

- If the PA request was originally submitted via the Portal, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal.
- If the PA request was originally submitted 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 PA request was originally submitted via mail or fax and the provider does *not* have a Portal account, the decision notice letter or returned amendment provider review letter will be sent by mail 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 or amendment request.

Topic #431

Amendments

Providers are required to use the Prior Authorization Amendment Request (F-11042 (07/12)) to amend an approved or modified PA (prior authorization) 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 member's ForwardHealth 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.

Topic #432

Appeals

If a PA (prior authorization) 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 (Division of Hearings and Appeals). 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.

To file an appeal, members may complete and submit a Request for Fair Hearing (DHA-28 (08/09)) 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 and the member. The letter includes instructions for the provider and for ForwardHealth.

If the DHA letter instructs the provider(s) to submit a claim for the service, each 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
313 Blettner Blvd
Madison WI 53784

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
313 Blettner Blvd
Madison WI 53784

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 members.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

   Division of Hearings and Appeals
   Department of Administration
   PO Box 7875
   Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #1106

Enddating

Providers are required to use the Prior Authorization Amendment Request (F-11042 (07/12)) to enddate most PA (prior authorization) 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 (Specialized Transmission Approval Technology-Prior Authorization) 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.

Topic #4739

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 (prior authorization) 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 and dental models will be returned once the amendment request is finalized.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

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.

Topic #5039

Searching for Previously Submitted Prior Authorization Requests on the Portal

Providers will be able to search for all previously submitted PA (prior authorization) 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

Topic #960

An Overview

Depending on the service being requested, most PA (prior authorization) requests must be comprised of the following:

- The PA/RF (Prior Authorization Request Form, F-11018 (07/12)), PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/12)), or PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (07/12)).
- A service-specific PA attachment(s).
- Additional supporting clinical documentation.

Topic #446

Attachments

In addition to the PA/RF (Prior Authorization Request Form, F-11018 (07/12)), PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (07/12)), or PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/12)), a service-specific PA (prior authorization) 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.

Topic #1390

To obtain PA for inpatient hospital services, the hospital or admitting or attending physician is required to submit the following:

- A PA/RF (Prior Authorization Request Form, F-11018 (07/12)).
- A PA request for substance abuse services is required to include the PA/PA (Prior Authorization/Physician Attachment, F-11016 (07/12)).

The hospital (not the physician) must submit PA requests for organ transplants and submit requests for the special payment rate for ventilator-dependent and brain injury care. To request the special payment rate, the hospital is required to complete and submit the Special Payment Rate Request for Ventilator-Dependent or Brain Injury Cases form (F-01168 (07/12)).

For other services requiring PA, if the physician does not submit a PA request, the hospital is encouraged to complete and submit the PA request in order to receive reimbursement for the services.

Topic #447

Obtaining Forms and Attachments

Providers may obtain paper versions of all PA (prior authorization) 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
313 Blettner Blvd
Madison WI 53784

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 (Portable Document Format) and fillable Microsoft® Word formats.

Web Prior Authorization Via the Portal

Certain providers may complete the PA/RF (Prior Authorization Request Form, F-11018 (07/12)) 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.

Topic #448

Prior Authorization Request Form

The PA/RF (Prior Authorization Request Form, F-11018 (07/12)) is used by ForwardHealth and is mandatory for most providers when requesting PA (prior authorization). 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 the claim for prior authorized services.

Topic #1389

Prior Authorization Request Form Completion Instructions for Inpatient Hospital Services

A sample PA/RF (Prior Authorization Request Form) for inpatient hospital services is available.

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 (prior authorization) requests, or processing provider claims for reimbursement. The use of the PA/RF (F-11018 (07/12)) 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/PA (Prior Authorization/Physician Attachment, F-11016 (07/12)) by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

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 (Wisconsin Chronic Disease Program) if the services requested on the PA/RF are for a WCDP member.

Element 2 — Process Type
Enter the appropriate three-digit process type from the list below. The process type is a three-digit code used to identify a category of service requested. Use process type 999 (Other) only if the requested category of service is not found in the list. PA and SOI (spell of illness) requests will be returned without adjudication if no process type is indicated.

117 — Physician Services (includes Family Planning Clinics, RHC (rural health clinics), and FQHCs (federally qualified health centers))
133 — Transplant Services
134 — AIDS (Acquired Immune Deficiency Syndrome) Services (hospital and nursing home)
135 — Ventilator Service
999 — Other (use only if the requested category or service is not listed above)

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 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 (National Provider Identifier) 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 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 the EVS (Wisconsin's Enrollment Verification System) 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 (International Classification of Diseases, Ninth Revision, Clinical Modification) 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 (Current Procedural Terminology) code; NUBC (National Uniform Billing Committee) code, HCPCS (Healthcare Common Procedure Coding System) code, or ICD-9-CM surgical code for each service/procedure/item requested.

Element 19 — Modifiers
Enter the modifier(s) corresponding to the procedure code listed if a modifier is required.

Element 20 — POS
Enter the appropriate POS (place of service) code designating where the requested service/procedure/item would be

provided/performed/dispensed.

21 — Inpatient Hospital
51 — Inpatient Psychiatric Facility
61 — Comprehensive Inpatient Rehabilitation Facility

Element 21 — Description of Service
Enter a written description corresponding to the appropriate CPT code, NUBC code, HCPCS code, or ICD-9-CM surgical code for each service/procedure/item requested.

Element 22 — QR
Enter the appropriate quantity (e.g., number of services, days' supply) requested for the procedure code listed.

Brain injury care services — Number of days
Hospital transplant — Per hospital stay
Hospital and nursing home AIDS services — Number of days
Hospital and nursing home ventilator services — Number of days

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 (Department of Health Services).

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).

Sample PA/RF for Inpatient Hospital Services

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11018 (10/08)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type	3. Telephone Number — Billing Provider
❑ HealthCheck "Other Services" ❑ Wisconsin Chronic Disease Program (WCDP)	133	(555) 555-5555

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)	5a. Billing Provider Number	5b. Billing Provider Taxonomy Code
I.M. BILLING PROVIDER 609 WILLOW ST ANYTOWN WI 55555-1234	0222222220	123456789X

SECTION II — MEMBER INFORMATION

6. Member Identification Number	7. Date of Birth — Member	8. Address — Member (Street, City, State, ZIP Code)
1234567890	MM/DD/CCYY	322 RIDGE ST ANYTOWN WI 55555

9. Name — Member (Last, First, Middle Initial)	10. Gender — Member
MEMBER, IM A	❑ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Diagnosis — Primary Code and Description	12. Start Date — SOI	13. First Date of Treatment — SOI
335.20 — Amyotrophic lateral sclerosis		

14. Diagnosis — Secondary Code and Description	15. Requested PA Start Date

16. Rendering Provider Number	17. Rendering Provider Taxonomy Code	18. Service Code	19. Modifiers 1	2	3	4	20. POS	21. Description of Service	22. QR	23. Charge
		41.02					21	Bone marrow transplant	1	XXXX.XX
		0819					21	Live donor	1	XXX.XX

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

24. Total Charges	XXXX.XX

25. **SIGNATURE** — Requesting Provider	26. Date Signed
I.M. Provider	MM/DD/CCYY

Topic #449

Supporting Clinical Documentation

Certain PA (prior authorization) 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 dental models will be returned to providers.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

General Information

Topic #4402

An Overview

The PA (prior authorization) review process includes 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.

Topic #434

Communication with Members

ForwardHealth recommends that providers inform members that PA (prior authorization) 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.

Topic #435

Definition

PA (prior authorization) 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.

Topic #5098

Designating an Address for Prior Authorization Correspondence

Correspondence related to PA (prior authorization) 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 dental models.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

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 (F-01181 (07/12)) form.

Topic #4383

Prior Authorization Numbers

Upon receipt of the PA/RF (Prior Authorization Request Form, F-11018 (07/12)), ForwardHealth will assign a PA (prior authorization) 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 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 (Specialized Transmission Approval Technology-Prior Authorization); 4 = STAT-PA; 5 = Portal; 6 = Portal; 7 = NCPDP (National Council for Prescription Drug Programs) transaction or 278 (278 Health Care Services Review - Request for Review and Response) transaction; 9 = MedSolutions
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.

Topic #436

Reasons for Prior Authorization

Only about four percent of all services covered by Wisconsin Medicaid require PA (prior authorization). 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 (Department of Health Services).

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.

Topic #437

Referrals to Out-of-State Providers

PA (prior authorization) may be granted to non-enrolled 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-enrolled provider, the referring provider should refer the out-of-state provider to the ForwardHealth Portal or Provider Services to obtain appropriate enrollment 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.

Topic #438

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 (prior authorization) 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 enrolled in Wisconsin Medicaid on the date the service is provided.
- The service is billed according to service-specific claim instructions.
- The provider meets 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.

Topic #1268

Sources of Information

Providers should verify that they have the most current sources of information regarding PA (prior authorization). 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.

Topic #812

Status Inquiries

Providers may inquire about the status of a PA (prior authorization) request through one of the following methods:

- Accessing WiCall, ForwardHealth's AVR (Automated Voice Response) system.
- Calling Provider Services.

Providers should have the 10-digit PA number available when making inquiries.

Grant and Expiration Dates

Topic #439

Backdating

Backdating an initial PA (prior authorization) request or SOI (spell of illness) 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 or SOI request.
- The request includes clinical justification for beginning the service before PA or SOI was granted.
- The request is received by ForwardHealth within 14 calendar days of the start of the provision of services.

Topic #440

Expiration Date

The expiration (end) date of an approved or modified PA (prior authorization) 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.

Topic #441

Grant Date

The grant (start) date of an approved or modified PA (prior authorization) 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.

Topic #442

Renewal Requests

To prevent a lapse in coverage or reimbursement for ongoing services, all renewal PA (prior authorization) 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.

Member Eligibility Changes

Topic #443

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 (Enrollment Verification System) before the services are provided at each visit.
- When the PA (prior authorization) 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.

Topic #444

Retroactive Disenrollment from State-Contracted MCOs

Occasionally, a service requiring fee-for-service PA (prior authorization) is performed during a member's enrollment period in a state-contracted MCO (managed care organization). 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 (date of service). 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.

Topic #445

Retroactive Enrollment

If a service(s) that requires PA (prior authorization) 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.

Review Process

Topic #450

Clerical Review

The first step of the PA (prior authorization) request review process is the clerical review. The provider, member, diagnosis, and treatment information indicated on the PA/RF (Prior Authorization Request Form, F-11018 (07/12)), PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (07/12)), and PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/12)) 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-enrolled.
- 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.

Topic #451

Clinical Review

Upon verifying the completeness and accuracy of clerical items, the PA (prior authorization) 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. DHS 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 (Department of Health Services).
- Standards of practice.
- Professional knowledge.
- Scientific literature.

Services Requiring Prior Authorization

Topic #1387

Acquired Immune Deficiency Syndrome — Acute Care

Hospitals are required to obtain PA (prior authorization) from Wisconsin Medicaid if they seek the Medicaid special AIDS (Acquired Immune Deficiency Syndrome) payment rate. Refer to the Inpatient Hospital State Plan for more information on AIDS PA criteria for acute and extended care.

To receive PA for AIDS acute care, the following criteria must be met:

- The patient must be eligible for BadgerCare Plus or Medicaid.
- The member must have a principle diagnosis of AIDS or HIV (Human Immunodeficiency Virus) infection (ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) code 042).
- Upon admission, the member must meet the intensity and severity criteria for acute care. The DHS (Department of Health Services) uses the intensity, severity, discharge indicators, and appropriate criteria to determine the appropriate level of care for the member.
- Sufficient documentation, such as a summary of the admission work-up, progress notes, or other supporting clinical evidence, must be provided upon request.

PA for the AIDS acute care per diem is granted for a limited period of time (usually not to exceed 30 days). If the patient will still meet the intensity and severity criteria for acute care at the time of the PA expiration date, the provider is required to submit another PA request for continued acute care authorization. ForwardHealth must receive the PA request on or before the expiration date because PA for continuing services may not be backdated.

Topic #1388

Acquired Immune Deficiency Syndrome — Extended Care

To receive PA (prior authorization) for AIDS (Acquired Immune Deficiency Syndrome) — extended care, the following criteria must be met:

- The patient must be eligible for BadgerCare Plus or Wisconsin Medicaid.
- The member must have a principal diagnosis of AIDS or HIV (Human Immunodeficiency Virus) infection (ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) code 042).
- The member is medically stable.
- Reasonable attempts at securing alternative placement that allows for correct infection control procedures and isolation techniques, as documented in social services notes, must have been unsuccessful and an appropriate POC (plan of care) and discharge plan must have been established.
- The degree of debilitation and amount of care required to care for the member must equal or exceed the level of skilled nursing care provided in a skilled nursing facility.
- Sufficient documentation supporting these criteria must be provided upon request.

PA for the extended care rate is for a defined period of time. If the member will still meet the intensity and severity criteria for extended care at the time of the PA expiration date, the provider is required to submit another PA request for continued extended

care authorization. ForwardHealth must receive the PA request on or before the expiration date because PA for continuing services may not be backdated.

The DHS (Department of Health Services) recognizes that the progression of illness may require acute care services during the period established for extended care. Therefore, during this period, acute care is approved (upon receiving PA for acute care) only after the hospital has provided an acute level of care for at least five consecutive days.

Topic #1384

An Overview

Hospitals are required to obtain PA (prior authorization) for the following services:

- Covered hospital services if provided out of state under nonemergency circumstances by nonborder status providers.
- Certain transplant services.
- Most HealthCheck "Other Services."

Hospitals are also required to obtain PA to receive enhanced reimbursement rates for the following services:

- AIDS (Acquired Immune Deficiency Syndrome) — acute care.
- AIDS — extended care.
- Brain injury care.
- Services provided at critical access hospitals.
- Ventilator-dependent care.

The following covered services require the rendering provider to obtain PA:

- Hospitalization for nonemergency dental services.
- Hospitalization for any other medical or surgical services noted in DHS 107.06(2), DHS 107.08(2)(c), DHS 107.10(2), DHS 107.16(2), DHS 107.17(2), DHS 107.18(2), DHS 107.19(2), and DHS 107.24(3), Wis. Admin. Code.

Topic #1386

Brain Injury Care

To receive the Medicaid special brain injury care payment rate, a hospital is required to be enrolled in Wisconsin Medicaid as a brain injury care provider. PA (prior authorization) is also required for the brain injury care-enrolled hospital to receive the special payment rate. To request the special payment rate, providers must complete and submit the Special Payment Rate Request for Ventilator-Dependent or Brain Injury Cases form (F-01168 (07/12)). Providers may access the Inpatient Hospital State Plan for more information.

Topic #1385

Transplant Services

Hospitals are required to obtain PA (prior authorization) for the following transplants:

- Bone marrow (including peripheral blood stem cell transplantation).
- Hematopietic stem cell (including cord blood stem cell transplantation).
- Other transplants not listed above.

For all transplants requiring PA, the hospital and the transplant physician are encouraged to jointly complete and submit a PA/RF (Prior Authorization Request Form, F-11018 (07/12)) and PA/PA (Prior Authorization/Physician Attachment, F-11016 (07/12)), including relevant patient information with the PA request.

Hospitals are not required to obtain PA for the following solid organ transplants:

- Cornea.
- Heart.
- Kidney.
- Liver.
- Lung.
- Pancreas.
- Small bowel.

Transplants involving combinations of the above organs (e.g., heart-lung) also do not require PA.

In cases of multiple organ transplants where no single CPT code describes the procedure performed, the provider should indicate each individual procedure code, if available, on the PA request.

Topic #1383

Ventilator-Dependent Care

Hospitals are required to receive PA (prior authorization) to be eligible for the special ventilator-dependent payment rate. To request the special payment rate, providers must complete and submit the Special Payment Rate Request for Ventilator-Dependent or Brain Injury Cases form (F-01168 (07/12)). The hospital is required to request approval for payment for the ventilator-dependent rate for a member's hospital stay based on criteria contained in the Inpatient Hospital State Plan.

To receive PA for claims reimbursement for ventilator-dependent care, the following criteria are required:

- The patient is eligible for BadgerCare Plus or Medicaid.
- The ventilator-dependent member is medically stable.
- The hospital does not have an inpatient unit identified and approved by Medicaid and dedicated to the care of this type of member.
- The member has been hospitalized continuously for at least 30 days prior to acceptance for the ventilator rate.
- Attempts at weaning the member from the ventilator have failed.
- Home care is an unacceptable alternative because of financial/economic hardship or because of the lack of an adequate support system.
- Nursing home placement is inappropriate.

Situations Requiring New Requests

Topic #452

Change in Billing Providers

Providers are required to submit a new PA (prior authorization) 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.

Topic #5197

Changes to Member Enrollment Status

Changes to a member's enrollment status may affect PA (prior authorization) 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.

Topic #5417

Prior Authorization for BadgerCare Plus Plans

Providers are required to obtain PA separately for the Standard Plan, the Benchmark Plan, the BadgerCare Plus Core Plan, and the BadgerCare Plus Basic Plan for the same or similar services. If a member's enrollment status changes, PA granted under one plan will not be valid for the other plans. Providers are required to submit new PA requests in these cases to obtain a valid PA for the member. Separate PAs are required due to differences in coverage between the Standard Plan, the Benchmark Plan, the Core Plan, and the Basic Plan.

Topic #453

Examples

Examples of when a new PA (prior authorization) 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.

Topic #454

Services Not Performed Before Expiration Date

Generally, a new PA (prior authorization) 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

Topic #12597

278 Health Care Services Review — Request for Review and Response Transaction

Providers may request PA (prior authorization) electronically using the 278 (278 Health Care Services Review — Request for Review and Response) transaction, the standard electronic format for health care service PA requests.

Compliance Testing

Trading partners may conduct compliance testing for the 278 transaction.

After receiving an "accepted" 999 (999 Functional Acknowledgment) for a test 278 transaction, trading partners are required to call the EDI (Electronic Data Interchange) Helpdesk to request the production 278 transaction set be assigned to them.

Submitting Prior Authorization Requests

Submitting an initial PA request using the 278 transaction does not result in a real-time approval and cannot be used to request PA for drugs and diabetic supplies.

After submitting a PA request via a 278 transaction, providers will receive a real-time response indicating whether the transaction is valid or invalid. If the transaction is invalid, the response will indicate the reject reason(s), and providers can correct and submit a new PA request using the 278 transaction. A real-time response indicating a valid 278 transaction will include a PA number and a pending status. The PA request will be placed in a status of "Pending - Fiscal Agent Review."

The 278 transaction does not allow providers to submit supporting clinical information as required to adjudicate the PA request.

Trading partners cannot submit the 278 transaction through PES (Provider Electronic Solutions). In order to submit the 278 transaction, trading partners will need to use their own software or contract with a software vendor.

Topic #455

Fax

Faxing of all PA (prior authorization) requests to ForwardHealth may eliminate one to three days of mail time. The following are recommendations to avoid delays when faxing PA requests:

- Providers should 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 (F-01176 (12/11))

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) 224-6124.

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 (Prior Authorization Request Form, F-11018 (07/12)) or the PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (07/12)) 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) 224-6124, 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 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.

Topic #458

ForwardHealth Portal Prior Authorization

Providers can use the PA (prior authorization) features on the ForwardHealth Portal to do the following:

- Submit PA requests and amendments for all services that require PA.
- Save a partially completed PA request and return at a later time to finish completing it.
- Upload PA attachments and additional supporting clinical documentation for PA requests.

- Receive decision notice letters and returned provider review letters.
- Correct returned PA requests and PA amendment requests.
- Change the status of a PA request from "Suspended" to "Pending."
- Submit additional supporting documentation for a PA request that is in "Suspended" or "Pending" status.
- Search and view previously submitted PA requests or saved PA requests.
- Print a PA cover sheet.

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 (National Provider Identifier) requirements, NPI and related data are required on PA requests 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 PA requests with a status of "Approved" or "Approved with Modifications."

Saving Partially Completed Prior Authorization Requests

Providers do not have to complete PA requests in one session; they can save partially completed PA requests at any point after the Member Information page has been completed by clicking on the Save and Complete Later button, which is at the bottom of each page. There is no limit to how many times PA requests can be saved.

Providers can complete partially saved PA requests at a later time by logging in to the secure Provider area of the Portal, navigating to the Prior Authorization home page, and clicking on the Complete a Saved PA Request link. This link takes the provider to a Saved PA Requests page containing all of the provider's PA requests that have been saved.

Once on the Saved PA Requests page, providers can select a specific PA request and choose to either continue completing it or delete it.

Note: The ability to save partially completed PA requests is only applicable to new PA requests. Providers cannot save partially completed PA amendments or corrections to returned PA requests or amendments.

30 Calendar Days to Submit or Re-Save Prior Authorization Requests

Providers must submit or re-save PA requests within 30 calendar days of the date the PA request was last saved. After 30 calendar days of inactivity, a PA request is automatically deleted, and the provider has to re-enter the entire PA request.

The Saved PA Requests page includes a list of deleted PA requests. This list is for information purposes only and includes saved PA requests that have been deleted due to inactivity (it does *not* include PA requests deleted by the provider). Neither providers nor ForwardHealth are able to retrieve PA requests that have been deleted.

Submitting Completed Prior Authorization Requests

ForwardHealth's initial receipt of a PA request occurs when the PA request is submitted on the Portal. Normal backdating policy applies based on the date of initial receipt, not on the last saved date. Providers receive a confirmation of receipt along with a PA number once a PA request is submitted on the Portal.

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 (Prior Authorization/"J" Code Attachment, F-11034 (07/12)) and display the form for the provider to complete. Certain PA attachments cannot be completed online or uploaded.

Providers may also upload an electronically completed version of the paper PA attachment form. However, when submitting a PA attachment electronically, ForwardHealth recommends completing the PA attachment online as opposed to uploading an electronically completed version of the paper attachment form to reduce the chances of the PA request being returned for clerical errors.

All PA request attachment forms are available on the Portal to download and print to submit by fax or mail.

Providers may also choose 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 (F-11159 (10/08)) 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 (Prior Authorization Request Form, F-11018 (07/12)) that was completed on the Portal.

Note: If the cover sheet could not be generated while submitting the PA request due to technical difficulties, providers can print the cover sheet from the main Portal PA page.

Before submitting any PA request 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 providers.

Additional Supporting Clinical Documentation

ForwardHealth accepts additional supporting clinical documentation when the information cannot be indicated on the required PA request forms and is pertinent for processing the PA request or PA amendment request. Providers have the following options for submitting additional supporting clinical information for PA requests or PA amendment requests:

- Upload electronically.
- Mail.
- Fax.

Providers can choose to upload electronic supporting information through the Portal in the following formats:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg).
- PDF (Portable Document Format) (.pdf).
- Rich Text Format (.rtf).
- Text File (.txt).
- OrthoCAD™ (.3dm) (for dental providers).

JPEG files must be stored with a ".jpg" or ".jpeg" extension; text files must be stored with a ".txt" extension; rich text format files must be stored with an ".rtf" extension; and PDF files must be stored with a ".pdf" extension. Dental OrthoCAD™ files are stored with a ".3dm" extension.

Microsoft Word files (.doc) cannot be uploaded but can be saved and uploaded in Rich Text Format or Text File formats.

In addition, providers can also upload additional supporting clinical documentation via the Portal when:

- Correcting a PA request or PA amendment request that is in a "Returned — Provider Review" status.
- Submitting a PA amendment request.

If submitting supporting clinical information via mail or fax, 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.

ForwardHealth will return PA requests and PA amendments requests when the additional documentation could have been indicated on the PA/RF and PA attachments or when the pertinent information is difficult to find.

"Suspended" Prior Authorization Requests

For PA requests in a "Suspended" status, the provider has the option to:

- Change a PA request status from "Suspended" to "Pending."
- Submit additional documentation for a PA request that is in "Suspended" or "Pending" status.

Changing a Prior Authorization Request from "Suspended" to "Pending"

The provider has the option of changing a PA request status from "Suspended — Provider Sending Info" to "Pending" if the provider determines that additional information will not be submitted. Changing the status from "Suspended — Provider Sending Info" to "Pending" will allow the PA request to be processed without waiting for additional information to be submitted. The provider can change the status by searching for the suspended PA request, checking the box indicating that the PA request is ready for processing without additional documentation, and clicking the Submit button to allow the PA request to be processed by ForwardHealth. There is an optional free form text box, which allows providers to explain or comment on why the PA request can be processed.

Submitting Additional Supporting Clinical Documentation for a Prior Authorization Request in "Suspended" or "Pending" Status

There is an Upload Documents for a PA link on the PA home page in the provider secured Home Page. By selecting that link, providers have the option of submitting additional supporting clinical documentation for a PA request that is in "Suspended" or "Pending" status. When submitting additional supporting clinical documentation for a PA request that is in "Suspended" status, providers can choose to have ForwardHealth begin processing the PA request or to keep the PA request suspended. Prior authorization requests in a "Pending" status are processed regardless.

Note: When the PA request is in a "Pending" status and the provider uploads additional supporting clinical documentation, there may be up to a four-hour delay before the documentation is available to ForwardHealth in the system. If the uploaded information was received after the PA request was processed and the PA request was returned for missing information, the provider may resubmit the PA request stating that the missing information was already uploaded.

Topic #456

Mail

Any type of PA (prior authorization) 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

313 Blettner Blvd
Madison WI 53784

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

Topic #457

STAT-PA

Providers can submit STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) 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 (prior authorization) requests.

NPI (National Provider Identifier) 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 submitted through STAT-PA for members enrolled in the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, or the BadgerCare Plus Basic Plan. PA requests for members enrolled in the Benchmark Plan, the Core Plan, and the Basic Plan may be submitted online via the ForwardHealth Portal or on paper.

Provider Enrollment and Ongoing Responsibilities

8

Archive Date:01/02/2013

Provider Enrollment and Ongoing Responsibilities:Documentation

Topic #6277

1099 Miscellaneous Forms

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

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

Topic #1640

Availability of Records to Authorized Personnel

The DHCAA (Division of Health Care Access and Accountability) 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 (prior authorization) requests, and enrollment. These records include, but are not limited to, medical/clinical and financial documents. Providers are obligated to ensure that the records are released to an authorized 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 (managed care organizations), including HMOs (health maintenance organizations) and SSI (Supplemental Security Income) HMOs, are not reimbursed for the reproduction costs covered in their contract with the DHS (Department of Health Services).

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

Topic #200

Confidentiality and Proper Disposal of Records

ForwardHealth supports member rights regarding the confidentiality of health care and other related records, including an applicant or member's billing information or medical claim records. An applicant or member has a right to have this information safeguarded, and the provider is obligated to protect that right. Use or disclosure of any information concerning an applicant or member (including an applicant or member's billing information or medical claim records) for any purpose not connected with

program administration is prohibited unless authorized by the applicant or member (program administration includes contacts with third-party payers that are necessary for pursuing third-party payment and the release of information as ordered by the court).

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

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

HIPAA Privacy and Security Regulations

Definition of Protected Health Information

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

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

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

Requirements Regarding "Unsecured" Protected Health Information

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

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

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

Actions Required for Proper Disposal of Records

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

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

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

on the NIST (National Institute of Standards and Technology) Web site.

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

Wisconsin Confidentiality Laws

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

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

"Personally Identifiable Data" Protected

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

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

Actions Required for Proper Disposal of Records

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

Businesses Affected

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

Continuing Responsibilities for All Providers After Ending Participation

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

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

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

Penalties for Violations

Any covered entity provider or provider's business associate who violates federal HIPAA regulations regarding the confidentiality

and proper disposal of health care and related records may be subject to criminal and/or civil penalties, including any or all of the following:

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

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

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

Topic #201

Financial Records

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

Topic #202

Medical Records

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

Topic #199

Member Access to Records

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

Fees for Health Care Records

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

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

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

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

For information regarding fees that may be charged to members for copies of health care records, refer to s. 146.83(3f), Wis. Stats.

Topic #203

Preparation and Maintenance of Records

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

Topic #204

Record Retention

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

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

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

Maintaining Confidentiality of Records

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

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

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

Reviews and Audits

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

Topic #205

Records Requests

Requests for billing or medical claim information regarding services reimbursed by ForwardHealth 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 ForwardHealth.

Request from a Member or Authorized Person

If the request for a member's billing information or medical claim records is from a member or authorized person acting on behalf of 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 copy of the material furnished to the requestor, along with a copy of their original request and medical authorization release to:

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

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

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

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

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

Request for a Statement from a Dual Eligible

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

Topic #1646

Release of Billing Information to Government Agencies

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

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

Ongoing Responsibilities

Topic #220

Accommodating Members with Disabilities

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

Topic #215

Change in Ownership

New provider enrollment 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 (Division of Quality Assurance) certification for Wisconsin Medicaid enrollment change in ownerships:

- Ambulatory surgery centers.
- ESRD (end-stage renal disease) services providers.
- FQHCs (federally qualified health centers).
- Home health agencies.
- Hospice providers.
- Hospitals (inpatient and outpatient).
- Nursing homes.
- Outpatient rehabilitation facilities.
- Rehabilitation agencies.
- RHCs (rural health clinics).

All changes in ownership must be reported in writing to ForwardHealth and new provider enrollment 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 enrollment effective date in the mail.

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

Repayment Following Change in Ownership

Medicaid-enrolled providers who sell or otherwise transfer their business or business assets are required to repay ForwardHealth for any erroneous payments or overpayments made to them 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 (Department of Health Services) 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.

Topic #1422

Change of Ownership Billing for Inpatient Hospitals

The date of discharge governs which NPI (National Provider Identifier) is used when a change of hospital ownership occurs. For example: A change of ownership occurs on July 1. A patient stay has DOS (date of service) from June 26 to July 2. The hospital submits the claim using the NPI effective July 1.

Topic #219

Civil Rights Compliance (Nondiscrimination)

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

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

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

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

- Denial of aid, care, services, or other benefits.
- Segregation or separate treatment.
- Restriction in any way of any advantage or privilege received by others. (There are some program restrictions based on eligibility classifications.)
- Treatment different from that given to others in the determination of eligibility.
- Refusing to provide an oral language interpreter to persons who are considered LEP (limited English proficient) at no cost to the LEP individual in order to provide meaningful access.

- Not providing translation of vital documents to the LEP groups who represent five percent or 1,000, whichever is smaller, in the provider's area of service delivery.

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

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

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

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

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

Title VI of the Civil Rights Act of 1964

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

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

Title VII of the Civil Rights Act of 1964

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

Federal Rehabilitation Act of 1973, Section 504

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

This act requires the provision of reasonable accommodations where the employer or service provider cannot show that the

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

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

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

Americans with Disabilities Act of 1990

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

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

Age Discrimination Act of 1975

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

Topic #198

Contracted Staff

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

Topic #216

Examples of Ongoing Responsibilities

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

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

Topic #217

Keeping Information Current

Types of Changes

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

- Address(es) — practice location and related information, mailing, PA (prior authorization), and/or financial.
- Business name.
- Contact name.
- Federal Tax ID number (IRS (Internal Revenue Service) number).
- Group affiliation.
- Licensure.
- NPI (National Provider Identifier).
- Ownership.
- Professional certification.
- Provider specialty.
- Supervisor of nonbilling providers.
- Taxonomy code.
- Telephone number, including area code.

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

- Incorrect reimbursement.
- Misdirected payment.
- Claim denial.
- Suspension of payments 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 required 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 enrolled, 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 (F-01181 (07/12)) 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 (Division of Quality Assurance) are required to notify the DQA of changes to physical address, changes of ownership, and facility closures by calling (608) 266-8481.

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.

Topic #577

Legal Framework

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

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

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

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

Topic #13277

Reporting Suspected Waste, Fraud, and Abuse

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

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

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

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

Reporting Suspected Fraud and Abuse

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

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

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

The following information is helpful when reporting fraud and abuse:

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

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

Prescription

Topic #525

General Requirements

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

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

Drug Enforcement Agency Number Audits

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

Members in Hospitals and Nursing Homes

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

Topic #11117

Opioid Monthly Prescription Fill Limit

Opioid drugs are limited to five prescription fills per calendar month for BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, BadgerCare Plus Basic Plan, Wisconsin Medicaid, and SeniorCare members.

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

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

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

Prescriber Responsibilities

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

Members enrolled in the Benchmark Plan, the Core Plan, and the Basic Plan are not eligible to receive an opioid monthly prescription fill limit.

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

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

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

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

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

Pharmacy Responsibilities

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

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

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

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

Exceptions

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

Members enrolled in the Benchmark Plan, the Core Plan, and the Basic Plan are not eligible to receive an opioid prescription fill limit exception.

Schedule III-V drugs

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

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

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

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

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

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

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

Schedule II Drugs

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

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

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

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

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

- The drug dispensed was a Schedule II drug and the opioid monthly prescription fill limit was exceeded.
- The pharmacy attempted to contact the prescriber (or the physician's agent), but the prescriber is unavailable (e.g., clinic is closed).

- The pharmacist is required to provide justification why it was medically necessary to dispense the Schedule II opioid before discussing with the prescriber an exception to the opioid monthly prescription fill limit.

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

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

Topic #523

Prescriber Information for Drug Prescriptions

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

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

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

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

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

Preferred Drug List

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

Prescriber Responsibilities for Non-preferred Drugs

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

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

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

For BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, and BadgerCare Plus Basic Plan members, prescribers should be aware of drugs covered by the benefit plan and write prescriptions for drugs that are covered by the plan.

If a noncovered drug is medically necessary for a Benchmark Plan, Core Plan, or Basic Plan member, the prescriber should inform the member the drug is not covered by the benefit plan. The prescriber should instruct the member to work with his or her pharmacy provider to determine whether or not the drug is covered by BadgerRx Gold.

Diagnosis-Restricted Drugs

Prescribers are required to include a diagnosis description on prescriptions for those drugs that are diagnosis-restricted.

Prescribing Drugs Manufactured by Companies Who Have Not Signed the Rebate Agreement

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

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

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

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

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

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

To submit a PA request for a drug without a signed rebate agreement, the prescriber should complete and submit the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/12)) to the pharmacy where the drug will be dispensed. Pharmacies should complete the PA/RF (Prior Authorization Request Form, F-11018 (07/12)) and submit both forms and any supporting documentation to ForwardHealth. PAs can be submitted by paper, fax, or on the ForwardHealth Portal.

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

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

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

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

Members Enrolled in SeniorCare (Levels 2b and 3)

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

Members Enrolled in the BadgerCare Plus Benchmark, the BadgerCare Plus Core Plan, and the BadgerCare Plus Basic Plan

PA is not available for drugs that are not included on the BadgerCare Plus Benchmark Plan Product List, BadgerCare Plus Core Plan Product List, BadgerCare Plus Core Plan Brand Name Drugs Quick Reference, and the BadgerCare Plus Basic Plan Product List. PA requests submitted for noncovered drugs will be returned to providers unprocessed and the services will not be covered. Members do not have appeal rights regarding returned PA requests for noncovered drugs.

Drug Utilization Review System

The federal OBRA (Omnibus Budget Reconciliation Act of 1990) (42 CFR Parts 456.703 and 456.705) called for a DUR (Drug Utilization Review) program for all Medicaid-covered drugs to improve the quality and cost-effectiveness of member care. ForwardHealth's prospective DUR system assists pharmacy providers in screening certain drug categories for clinically important potential drug therapy problems before the prescription is dispensed to the member. The DUR system checks the member's entire drug history regardless of where the drug was dispensed or by whom it was prescribed.

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

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

Prospective Drug Utilization Review's Impact on Prescribers

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

Drugs with Three-Month Supply Requirement

ForwardHealth has identified a list of drugs for which pharmacy providers are required to dispense a three-month supply. The same list includes drugs that may be (but are not required to be) dispensed in a three-month supply.

Member Benefits

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

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

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

Prescription Quantity

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

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

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

Prescription Mail Delivery

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

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

Noncovered Drugs

The following drugs are not covered:

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

SeniorCare

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

Topic #4346

Tamper-Resistant Prescription Pad Requirement

Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of

2007 imposed a requirement on prescriptions paid for by Medicaid, SeniorCare, or BadgerCare fee-for-service. The law requires that all written or computer-generated prescriptions that are given to a patient to take to a pharmacy must be written or printed on tamper-resistant prescription pads or tamper-resistant computer paper. This requirement applies to prescriptions for both controlled and noncontrolled substances.

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

Required Features for Tamper-Resistant Prescription Pads or Computer Paper

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

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

Exclusions to Tamper-Resistant Prescription Pad Requirement

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

- Prescriptions faxed directly from the prescriber to the pharmacy.
- Prescriptions electronically transmitted directly from the prescriber to the pharmacy.
- Prescriptions telephoned directly from the prescriber to the pharmacy.
- Prescriptions provided to members in nursing facilities, intermediate care facilities for the mentally retarded, and other specified institutional and clinical settings to the extent that drugs are part of their overall rate. However, written prescriptions filled by a pharmacy outside the walls of the facility are subject to the tamper-resistant requirement.

72-Hour Grace Period

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

Coordination of Benefits

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

Retroactive Medicaid Eligibility

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

Penalty for Noncompliance

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

Provider Enrollment

Topic #899

CLIA Certification or Waiver

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

CLIA Enrollment

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

CLIA Regulations

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

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

Scope of CLIA

CLIA governs all laboratory operations including the following:

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

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

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

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

CLIA Certification Types

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

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

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

Applying for CLIA Certification

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

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

Providers Required to Report Changes

Providers are required to notify Provider Maintenance in writing within 30 days of any change(s) in ownership, name, location, or director. Also, providers are required to notify Provider Maintenance of changes in CLIA certificate types immediately and within six months when a specialty/subspecialty is added or deleted. Following is the address for providing written notification to Provider Maintenance:

ForwardHealth
Provider Maintenance
313 Blettner Blvd
Madison WI 53784

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

Topic #3969

Categories of Enrollment

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

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

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

Billing/Rendering Provider

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

Rendering-Only Provider

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

Billing-Only Provider (Including Group Billing)

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

Group Billing

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

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

Individual practitioners within group practices are required to be Medicaid-enrolled because these groups are required to identify

the provider who rendered the service on claims. Claims indicating these group billing providers that are submitted without a rendering provider are denied.

Topic #1425

Discharge Billing Requirements

Drugs, DME (durable medical equipment), and DMS (disposable medical supplies) provided at discharge are not reimbursable services for inpatient hospitals. Providers who submit claims for these services are required to be appropriately enrolled as pharmacies or individual medical suppliers and follow the policies and procedures for their provider type.

Topic #14137

Enrollment Requirements Due to the Affordable Care Act

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

- Providers will be assigned a risk level of limited, moderate, or high. Most of the risk levels have been established by the CMS (Centers for Medicare and Medicaid Services) based on an assessment of potential fraud, waste, and abuse for each provider type.
- Providers will be screened according to their assigned risk level. Screenings will be conducted during initial enrollment and revalidation.
- Certain provider types will be subject to an enrollment application fee of $523. This fee has been federally mandated and may be adjusted annually. The fee is used to offset the cost of conducting screening activities.
- The enrollment process will require additional information. During the enrollment process, providers are required to provide additional information for persons with an ownership or control interest, managing employees, and agents. "Persons" in this instance may mean a person or a corporation.
- Revalidation will occur at least every three to five years.
- Ordering and referring physicians or other professionals will be required to be enrolled as a participating Medicaid provider.
- Payment suspensions will be imposed on providers based on a credible allegation of fraud.

ForwardHealth Implementation of Affordable Care Act Requirements to Date

Provider Screenings

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

- Checking federal databases, which include:
    - The SSA (Social Security Administration's) Death Master File.
    - The NPPES (National Plan and Provider Enumeration System).
    - OIG (Office of the Inspector General) LEIE (List of Excluded Individuals/Entities).

    - EPLS (The Excluded Parties List System).
    - MED (Medicare Exclusion Database).
- Verifying licenses are appropriate in accordance with state laws and that there are no current limitations on the license.

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

ForwardHealth will deny enrollment or terminate the enrollment of any provider where any person with a five percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years, or if invalid licensure information is found.

Additional Information Needed During Provider Enrollment

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

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

- First and last name.
- Provider's SSNs (Social Security numbers).
- Dates of birth.
- Street address, city, state, and ZIP+4 code.

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

- Legal business name.
- Tax identification number.
- Business street address, city, state, ZIP+4 code.

Providers are required to submit the following information at the time of enrollment and revalidation for their managing employees and agents:

- First and last name.
- Employees' and agents' SSNs.
- Dates of birth.
- Street address, city, state, and ZIP+4 code.

Topic #3430

Licensed Hospital Facility

To be enrolled and reimbursed as a hospital by Wisconsin Medicaid, a facility must be licensed as a hospital by the Office of the Secretary of the DHS (Department of Health Services), DQA (Division of Quality Assurance) under ch. 50, Wis. Stats. Therefore, a service may be reimbursed at Medicaid outpatient hospital rates only if it is provided in a building that is licensed by the DQA as a hospital. For licensure purposes, the hospital includes all inpatient rooms, surgical suites, and other facilities where services are performed.

Wisconsin Medicaid's reimbursement methodologies differ from the methodologies of the federal Medicare program. Medicare

designates a provider-based status to certain remote or satellite facilities that are not located in a DQA-licensed hospital. Facilities with a provider-based status (according to 42 CFR s. 413.65) receive Medicare's hospital reimbursement rates. Wisconsin Medicaid does not recognize Medicare's provider-based designation for these facilities, and therefore, services provided at these facilities are not reimbursed according to Medicare's reimbursement methodologies.

Because Wisconsin Medicaid does not recognize Medicare's provider-based designation, claims for services provided at these facilities may not be submitted using a hospital's Medicaid provider number. Claims for services provided at a facility outside a Medicaid-enrolled and DQA-licensed hospital must be submitted using the Medicaid provider number of that outside facility. For example, when a claim is submitted by a freestanding facility that is outside, but affiliated with, a Medicaid-enrolled hospital or located on the same property as a Medicaid-enrolled hospital, the billing provider number of the freestanding facility must be indicated on the claim.

Topic #193

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 *ForwardHealth Updates*. *Updates* are available for viewing and downloading on the ForwardHealth Publications page.

Topic #194

Non-enrolled In-State Emergency Providers

ForwardHealth reimburses non-enrolled 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 Medicaid-enrolled providers rendering the same service.

Claims from non-enrolled in-state providers must be submitted with an In-State Emergency Provider Data Sheet (F-11002 (07/12)). The In-State Emergency Provider Data Sheet provides ForwardHealth with minimal tax and licensure information.

Non-enrolled in-state providers may call Provider Services with questions.

Topic #1424

Professional and Other Services Needing Separate Enrollment

Certain providers who provide professional and other services within an inpatient hospital require separate Medicaid enrollment for the providers. These include the following:

- Air, water, and land ambulance providers.
- AAs (anesthesiologist assistants).
- Audiologists.
- CRNAs (certified registered nurse anesthetists).
- Chiropractors.
- Dentists.
- DME (durable medical equipment) and DMS (disposable medical supplies) suppliers for nonhospital use.

- Hearing aid providers.
- Nurse midwives.
- Nurse practitioners.
- Optometrists.
- Pharmacies (for take-home drugs on the date of discharge).
- Physician assistants.
- Physicians.
- Podiatrists.
- Psychiatrists.
- Psychologists.
- SMV (specialized medical vehicle) providers.

Topic #4457

Provider Addresses

ForwardHealth has the capability to store the following types of addresses and contact information:

- *Practice location address and related information.* This address is where the provider's office is physically located and where records are normally kept. Additional information for the practice location includes the provider's office telephone number and the telephone number for members' use. With limited exceptions, the practice location and telephone number for members' use are published in a provider directory made available to the public.
- *Mailing address.* This address is where ForwardHealth will mail general information and correspondence. Providers should indicate accurate address information to aid in proper mail delivery.
- *PA (prior authorization) address.* This address is where ForwardHealth will mail PA information.
- *Financial addresses.* Two separate financial addresses are stored for ForwardHealth. The checks address is where ForwardHealth will mail paper checks. The 1099 mailing address is where ForwardHealth will mail IRS Form 1099.

Providers may submit additional address information or modify their current information through the ForwardHealth Portal or by using the Provider Change of Address or Status (F-01181 (07/12)) form.

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

Topic #14157

Provider Enrollment Information Home Page

ForwardHealth has consolidated all information providers will need for the enrollment process in one location on the ForwardHealth Portal. For information related to enrollment criteria and to complete online provider enrollment applications, providers should refer to the Provider Enrollment Information home page.

The Provider Enrollment Information home page includes enrollment applications for each provider type and specialty eligible for enrollment with Wisconsin Medicaid. Prior to enrolling, providers may consult a provider enrollment criteria menu, which is a reference for each individual provider type detailing the information the provider may need to gather before beginning the enrollment process, including:

- Links to enrollment criteria for each provider type.
- Provider terms of reimbursement.
- Disclosure information.

- Category of enrollment.
- Additional documents needed (when applicable).

Providers will also have access to a list of links related to the enrollment process, including:

- General enrollment information.
- Regulations and forms.
- Provider type-specific enrollment information.
- In-state and out-of-state emergency enrollment information.
- Contact information.

Information regarding enrollment policy and billing instructions may still be found in the Online Handbook.

Topic #1931

Provider Type and Specialty Changes

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

Topic #14317

Terminology to Know for Provider Enrollment

Due to the ACA (Affordable Care Act), ForwardHealth has adopted new terminology. The following table includes new terminology that will be useful to providers during the provider enrollment and revalidation processes. Providers may refer to the Medicaid rule 42 CFR s. 455.101 for more information.

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

Person with an ownership or control interest	A person or corporation for which one or more of the following applies: • Has an ownership interest totaling five percent or more in a disclosing entity. • Has an indirect ownership interest equal to five percent or more in a disclosing entity. • Has a combination of direct and indirect ownership interest equal to five percent or more in a disclosing entity. • Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or asset of the disclosing entity. • Is an officer or director of a disclosing entity that is organized as a corporation. • Is a person in a disclosing entity that is organized as a partnership.
Subcontractor	• An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or, • An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.
Re-enrollment	Re-enrollment of a provider whose Medicaid enrollment has ended for any reason other than sanctions or failure to revalidate may be re-enrolled as long as all licensure and enrollment requirements are met. If a provider's enrollment with Wisconsin Medicaid lapses for longer than one year, they will have to re-enroll as a "new" provider. Providers should note that when they re-enroll, application fees and screening activities may apply. Re-enrollment was formerly known as re-instate.
Revalidation	All enrolled providers are required to revalidate their enrollment information every three years to continue their participation with Wisconsin Medicaid. Revalidation was formerly known as recertification.

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

Provider Numbers

Topic #3421

Provider Identification

Health Care Providers

Health care providers are required to indicate an NPI (National Provider Identifier) on enrollment applications and electronic and paper transactions submitted to ForwardHealth.

The NPI is a 10-digit number obtained through the NPPES (National Plan and Provider Enumeration System).

Providers should ensure that they have obtained an appropriate NPI prior to beginning their enrollment application. There are two kinds of NPIs:

- Entity Type 1 NPIs are for individuals who provide health care, such as physicians, dentists, and chiropractors.
- Entity Type 2 NPIs are for organizations that provide health care, such as hospitals, group practices, pharmacies, and home health agencies.

It is possible for a provider to qualify for both Entity Type 1 and Entity Type 2 NPIs. For example, an individual physical therapist may also be the owner of a therapy group that is a corporation and have two Wisconsin Medicaid enrollments — one enrollment as an individual physical therapist and the other enrollment as the physical therapy group. A Type 1 NPI for the individual enrollment and a Type 2 NPI for the group enrollment are required.

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

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

Non-healthcare Providers

Non-healthcare providers, such as SMV (specialized medical vehicle) providers, personal care agencies, and blood banks, are exempt from federal NPI requirements. Providers exempt from federal NPI requirements are assigned a Medicaid provider number once their enrollment application is accepted; they are required to indicate this Medicaid provider number on electronic and paper transactions submitted to ForwardHealth.

Topic #12337

Subpart National Provider Identifiers

Hospitals are asked to provide ForwardHealth with all subpart NPIs (National Provider Identifiers) they use with other payers, including Medicare. Providers are required to provide ForwardHealth with only those subpart NPIs that represent hospital units that are not separately enrolled with Wisconsin Medicaid. ForwardHealth uses subpart NPIs as additional identifiers that are linked to the hospital's enrollment.

Once a subpart NPI is on file with Wisconsin Medicaid, a hospital provider may use the subpart NPI as the billing provider on

claims. On adjustments, providers are reminded that the billing provider NPI on the original claim and the billing provider NPI on the adjustment must match.

Providers may add or revise subpart NPI information on file with ForwardHealth using the demographic maintenance link on the secure Provider area of the ForwardHealth Portal. In addition to subpart NPIs, providers may add to or revise the taxonomy codes corresponding to the subpart using this function. Once submitted, hospital providers may check demographic maintenance periodically to find out whether ForwardHealth has added the subparts to the provider file. Providers who do not have secure Portal access may use the revised Provider Change of Address or Status (F-01181 (07/12)) form to report subpart NPIs and corresponding taxonomy codes.

Subpart NPIs on file with ForwardHealth may be used on claim transactions, PA (prior authorization) requests, WiCall, enrollment verification, provider enrollment, Provider Services inquiries, and the Portal.

Topic #5096

Taxonomy Codes

Taxonomy codes are standard code sets used to provide information about provider type and specialty for the provider's enrollment. ForwardHealth uses taxonomy codes as additional data for correctly matching the NPI (National Provider Identifier) to the provider file.

Providers are required to use a taxonomy code when the NPI reported to ForwardHealth corresponds to multiple enrollments and the provider's practice location ZIP+4 code does not uniquely identify the provider.

Providers are allowed to report multiple taxonomy codes to ForwardHealth as long as the codes accurately describe the provider type and specialty for the provider's enrollment. When doing business with ForwardHealth, providers may use any one of the reported codes. Providers who report multiple taxonomy codes will be required to designate one of the codes as the primary taxonomy code; ForwardHealth will use this primary code for identification purposes.

Providers who wish to change their taxonomy code or add additional taxonomy codes may do so using the demographic maintenance tool found in the secure Provider area of the ForwardHealth Portal. Refer to the Demographic Maintenance Tool User Guide on the Portal User Guides page of the Portal for more detailed instructions. Most taxonomy code changes entered through the demographic maintenance tool will take effect in real time; providers may use the new codes immediately on transactions.

Alternatively, providers may use the Provider Change of Address or Status (F-01181 (07/12)) form to report new taxonomy codes. Providers who submit new taxonomy codes using the Provider Change of Address or Status form will need to check the demographic maintenance tool to verify ForwardHealth has received and added the new taxonomy codes prior to using them on transactions.

Omission of a taxonomy code when it is required as additional data to identify the provider will cause claims and other transactions to be denied or delayed in processing.

Note: Taxonomy codes do not change provider enrollment or affect reimbursement terms.

Topic #5097

ZIP Code

The ZIP code of a provider's practice location address on file with ForwardHealth must be a ZIP+4 code. The ZIP+4 code helps to identify a provider when the NPI (National Provider Identifier) reported to ForwardHealth corresponds to multiple enrollments

and the reported taxonomy code does not uniquely identify the provider.

When a ZIP+4 code is required to identify a provider, omission of it will cause claims and other transactions to be denied or delayed in processing.

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

Provider Rights

Topic #208

A Comprehensive Overview of Provider Rights

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

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

Topic #207

Ending Participation

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

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

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

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

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

ForwardHealth
Provider Maintenance
313 Blettner Blvd
Madison WI 53784

If the provider fails to specify an effective date in the notice of termination, ForwardHealth may terminate the provider on the date the notice is received.

Topic #209

Hearing Requests

A provider who wishes to contest a DHS (Department of Health Services) action or inaction for which due process is required

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

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

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

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

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

Topic #210

Limiting the Number of Members

If providers choose to limit the number of members they see, they cannot accept a member as a private-pay patient. Providers should instead refer the member to another ForwardHealth provider.

Persons applying for or receiving benefits are protected against discrimination based on race, color, national origin, sex, religion, age, disability, or association with a person with a disability.

Topic #206

Requesting Discretionary Waivers and Variances

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

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

Requirements

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

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

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

Application

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

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

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

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

Revalidation

Topic #8517

An Overview

Each year approximately one-third of all Medicaid-enrolled providers undergo a revalidation process, during which they update their enrollment information and sign the Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation. Providers are required to complete the revalidation process to continue their participation with Wisconsin Medicaid. Wisconsin Medicaid will notify providers when they need to revalidate their enrollment information and provide instructions on how to complete the revalidation process. Most providers will conduct their revalidation process on the ForwardHealth Portal.

Topic #8521

Checking the Status of a Revalidation Application

Providers may check the status of their revalidation on the ForwardHealth Portal by entering the ATN (application tracking number) from the Provider Revalidation Notice and pressing "Search."

Providers will receive one of the following status responses:

- "Approved." ForwardHealth has reviewed the revalidation materials and all requirements have been met. ForwardHealth is completing updates to provider files.
- "Awaiting Additional Info." ForwardHealth has reviewed the revalidation materials and has requested additional information from the provider. Providers will receive a letter via mail when additional materials or information are required to complete processing of the revalidation materials.
- "Awaiting Follow-On Documents." ForwardHealth requires additional paper documents to process the revalidation. After the provider has submitted revalidation information online via the Portal, the final screen will list additional documents the provider must mail to ForwardHealth. ForwardHealth cannot complete processing until these documents are received. This status is primarily used for SMV (specialized medical vehicle) provider revalidation.
- "Denied." The provider's revalidation has been denied.
- "Failure to Revalidate." The provider has not revalidated by the established revalidation deadline.
- "In Process." The revalidation materials are in the process of being reviewed by ForwardHealth.
- "Paper Requested." The provider requested a paper revalidation application and ForwardHealth has not received the paper application yet.
- "Revalidation Initiated." The Provider Revalidation Notice and PIN (personal identification number) letter have been sent to the provider. The provider has not started the revalidation process yet.
- "Revalidated." The provider has successfully completed revalidation. There are no actions necessary by the provider.
- "Referred To DHS." ForwardHealth has referred the provider revalidation materials to the State Enrollment Specialist for revalidation determination.

Note: Status responses may not yet reflect changes in certification terminology which are being made in compliance with the ACA (Affordable Care Act).

Topic #8519

Notification Letters

Providers undergoing the revalidation process will receive two important letters in the mail from ForwardHealth:

- The Provider Revalidation Notice. This is the first notice to providers. The Provider Revalidation Notice contains identifying information about the provider who is required to complete the revalidation process, the revalidation deadline, and the ATN (application tracking number) assigned to the provider. The ATN is used when logging in to the ForwardHealth Portal to complete the revalidation process and also serves as the tracking number when checking the status of the provider's revalidation application.
- The PIN (personal identification number) letter. Providers will receive this notice a few days after the Provider Revalidation Notice. The PIN letter will contain a revalidation PIN and instructions on logging in to the Portal to complete the revalidation process.

The letters are sent to the mailing address on file with Wisconsin Medicaid. Providers should read these letters carefully and keep them for reference. The letters contain information necessary to log in to the secure Revalidation area of the Portal to complete the revalidation process. If a provider needs to replace one of the letters, the revalidation process will be delayed.

Topic #8522

Revalidation Completed by an Authorized Representative

A provider has several options for submitting information to the DHS (Department of Health Services), including electronic and Web-based submission methodologies that require the input of secure and discrete access codes but not written provider signatures.

The provider has sole responsibility for maintaining the privacy and security of any access code the provider uses to submit information to the DHS, and any individual who submits information using such an access code does so on behalf of the provider, regardless of whether the provider gave the access code to the individual or had knowledge that the individual knew the access code or used it to submit information to the DHS.

Sanctions

Topic #211

Intermediate Sanctions

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

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

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

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

Topic #212

Involuntary Termination

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

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

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

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

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

Topic #213

Sanctions for Collecting Payment from Members

Under state and federal laws, if a provider inappropriately collects payment from an enrolled member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid enrollment. In addition, the provider may also be fined not more than $25,000, or imprisoned not more than five years, or both, pursuant to 42 USC s. 1320a-7b(d) or s. 49.49(3m), Wis. Stats.

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

Topic #214

Withholding Payments

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

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

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

Reimbursement

9

Archive Date:01/02/2013

Reimbursement:Amounts

Topic #258

Acceptance of Payment

The amounts allowed as payment for covered services must be accepted as payment in full. Therefore, total payment for the service (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 or Medicaid) may not exceed the allowed amount. As a result, providers may not collect payment from a member, or authorized person acting on behalf of the member, for the difference between their usual and customary charge and the allowed amount for a service (i.e., balance billing).

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

Topic #9557

Basic Plan Reimbursement Rates

Inpatient hospitals will be reimbursed the full DRG (diagnosis related group) base payment, excluding hospital access payments. Providers should note they will only be reimbursed the base component of the DRG and that no outlier costs are reimbursed. Outlier costs may not be billed to the member. During the deductible period the member is liable for payment at the Basic Plan reimbursement rate, which excludes hospital access payments and outlier costs. After the member's $7,500.00 deductible is met, ForwardHealth will reimburse hospital providers the DRG base payment for all additional inpatient stays in that enrollment year, excluding hospital access payments and outlier costs.

Topic #694

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.

Topic #7017

Core Plan Reimbursement Rates

Rates of reimbursement for inpatient and outpatient hospital services covered under the BadgerCare Plus Core Plan do not include hospital access payments or any other type of payment increase funded from the hospital assessment trust fund. Rates for hospital services are published on the ForwardHealth Portal.

Topic #1381

Diagnosis Related Groups

Wisconsin Medicaid uses a payment system for enrolled in-state, out-of-state, and border-status hospitals based on DRGs (Diagnosis Related Groups). The DRG system covers the following:

- Acute care general hospitals.
- IMD (institution for mental disease) hospitals, except state-operated IMD hospitals.

The following are excluded from the DRG system and are paid under a hospital-specific daily rate:

- Rehabilitation hospitals.
- State-operated IMD hospitals.
- State-operated veteran's hospitals.

The following professional and other services are excluded from the inpatient DRG:

- Air, water, and land ambulance.
- Anesthesia assistants.
- Audiologists.
- CRNA (Certified registered nurse anesthetists).
- Chiropractors.
- Dentists.
- Hearing aid dealers.
- Independent nurse practitioners.
- Providers of medical equipment and supplies for non-hospital use.
- Nurse midwives.
- Occupational therapy.
- Optometrists.
- Physical therapy.
- Physicians.
- Physician assistants.
- Podiatrists.
- Psychiatrists.
- Psychologists.
- SMV (Specialized Medical Vehicle) providers.
- Speech-language pathology

Topic #8117

Electronic Funds Transfer

EFT (electronic funds transfer) allows ForwardHealth to directly deposit payments into a provider's designated bank account for a more efficient delivery of payments than the current process of mailing paper checks. EFT is secure, eliminates paper, and reduces the uncertainty of possible delays in mail delivery.

Only in-state and border-status providers who submit claims and MCOs (managed care organizations) are eligible to receive EFT payments.

Provider Exceptions

EFT payments are not available to the following providers:

- In-state emergency providers.
- Out-of-state providers.
- Out-of-country providers.
- SMV (specialized medical vehicle) providers during their provisional enrollment period.

Enrolling in Electronic Funds Transfer

A ForwardHealth Portal account is required to enroll into EFT as all enrollments must be completed via a secure Provider Portal account or a secure MCO Portal account. Paper enrollments are not accepted. A separate EFT enrollment is required for each financial payer a provider bills.

Providers who do not have a Portal account may Request Portal Access online. Providers may also call the Portal Helpdesk for assistance in requesting a Portal account.

The following guidelines apply to EFT enrollment:

- Only a Portal Administrator or a clerk that has been assigned the "EFT" role on the Portal may complete the EFT enrollment information.
- Organizations cannot revert back to receiving paper checks once enrolled in EFT.
- Organizations may change their EFT information at any time.
- Organizations will continue to receive their Remittance Advice as they do currently.

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

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

Recoupment and Reversals

Enrollment in EFT does not change the current process of recouping funds. Overpayments and recoupment of funds will continue to be conducted through the reduction of payments.

Note: Enrolling in EFT does not authorize ForwardHealth to make unauthorized debits to the provider's EFT account; however, in some instances an EFT reversal of payment may be necessary. For example, if the system generates a payment twice or the amount entered manually consists of an incorrect value (e.g., a decimal point is omitted creating a $50,000 keyed value for a $500 claim), a reversal will take place to correct the error and resend the correct transaction value. ForwardHealth will notify the designated EFT contact person of an EFT reversal if a payment is made in error due to a system processing or manual data entry error.

Problem Resolution

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

Topic #1377

Hospital Services Exempt From Diagnosis Related Group-Based Payment System

Payment for certain specialized inpatient services are exempt from the DRG (Diagnosis Related Group)-based payment system. These services can receive enhanced reimbursement by obtaining PA (prior authorization). The following are exempted services:

- AIDS (Acquired Immune Deficiency Syndrome) — Acute care.
- AIDS (Acquired Immune Deficiency Syndrome) — Extended care.
- Brain injury care.
- Services provided at critical access hospitals.
- Ventilator-dependent care.

The Inpatient Hospital State Plan contains special provisions for payment of each of these DRG-exempted services.

Topic #1380

Hospital Services Included in the Diagnosis-Related Group-Based Payment System

Most covered services provided during an inpatient stay are hospital inpatient services that are included in the DRG (Diagnosis Related Group)-based payment system. The following hospital services are also considered part of the DRG-based payment system:

- Drugs, except take-home drugs on the date of discharge.
- Services by independent therapists (PT (physical therapy), OT (occupational therapy), SLP (speech and language pathology), etc.).
- Services of residents and interns.
- Services provided by another hospital (except on the date of admission and discharge).
- Services provided by social workers and substance abuse counselors.
- Technical services by independent imaging groups (X-ray, MRI, etc.).
- Technical services provided by a nonhospital laboratory.

Any other services, including professional services, are not covered under the DRG payment.

Topic #1379

Interim Payment for Long Length of Stay

Hospitals may interim bill for DRG (Diagnosis Related Group) claims if the member has been an inpatient at the hospital for more than 60 days. Submit claims for interim payment with patient status code "30" (still a patient) in Item 22 of the UB-04 Claim Form.

To receive final payment for the claim, submit an adjustment to the original claim.

If additional interim payments are necessary, use an adjustment form for the subsequent requests. At least 30 additional days are required to elapse since the "through" date on any previous claim or adjustment. Write "interim payment for long length of stay" as the adjustment reason. Attach an updated UB-04 Claim Form to the request. On the updated UB-04 Claim Form include:

- A current patient status code in Item 22.
- All accumulated charges since admission (not just the additional charges since the first interim payment).
- All other updated information showing all events up to the "through" date on the claim (e.g., additional surgical procedure codes, new discharge diagnosis).

Topic #14877

Neonatal Diagnosis Related Group Enhancement Table

Enhancement Logic:

Look at each row from top to bottom until a match is found.

20

Base DRG	Length of Stay	Admit Source	Patient Status	Diagnosis Group	ICD9 Procedure Group	Enhanced DRG Assigned
795	<=1	4/A/D	20			9602
795	<=1	N/A	20			9601
795	<=4	N/A	02/05			9604
795		N/A	20	5010 — 1000 — 1499 grams		9637
795		N/A	20	5009 — 750 — 999 grams		9620
795		N/A	20	5008 — Under 750 grams		9610
795		N/A		5012 — 2000 — 2500 grams	1032 — DRG or Surg Proc V28	9650
795		N/A		5012 — 2000 — 2500 grams		9670
795		N/A		5011 — 1500 — 1999 grams	1032 — DRG or Surg Proc V28	9648
795		N/A		5011 — 1500 — 1999 grams		9649
795		N/A		5010 — 1000 — 1499 grams	1032 — DRG or Surg Proc V28	9638
795		N/A		5010 — 1000 — 1499 grams		9639
795		N/A		5009 — 750 — 999 grams		9624
795		N/A		5008 — Under 750 grams		9614
795		N/A			1032 — DRG or Surg Proc V28	9680
795		N/A				9678
794	<=1	4/A/D	20			9602
794	<=1	N/A	20			9601
794	<=4	N/A	02/05			9604
794		N/A	20	5010 — 1000 — 1499 grams		9637

794		N/A	20	5009 — 750 — 999 grams		9620
794		N/A	20	5008 — Under 750 grams		9610
794		N/A		5012 — 2000 — 2500 grams	1032 — DRG or Surg Proc V28	9650
794		N/A		5012 — 2000 — 2500 grams		9657
794		N/A		5011 — 1500 — 1999 grams	1032 — DRG or Surg Proc V28	9648
794		N/A		5011 — 1500 — 1999 grams		9649
794		N/A		5010 — 1000 — 1499 grams	1032 — DRG or Surg Proc V28	9638
794		N/A		5010 — 1000 — 1499 grams		9639
794		N/A		5009 — 750 — 999 grams		9624
794		N/A		5008 — Under 750 grams		9614
794		N/A			1032 — DRG or Surg Proc V28	9680
794		N/A				9677
793	<=1	4/A/D	20			9602
793	<=1	N/A	20			9601
793	<=4	N/A	02/05			9604
793		N/A	20	5010 — 1000 — 1499 grams		9637
793		N/A	20	5009 — 750 — 999 grams		9620
793		N/A	20	5008 — Under 750 grams		9610
793		N/A		5012 — 2000 — 2500 grams	1032 — DRG or Surg Proc V28	9650
793		N/A		5012 — 2000 — 2500 grams		9656
793		N/A		5011 — 1500 — 1999 grams	1032 — DRG or Surg Proc V28	9648
793		N/A		5011 — 1500 — 1999 grams		9649
793		N/A		5010 — 1000 — 1499 grams	1032 — DRG or Surg Proc V28	9638
793		N/A		5010 — 1000 — 1499 grams		9639

793		N/A		5009 — 750 — 999 grams		9624
793		N/A		5008 — Under 750 grams		9614
793		N/A			1032 — DRG or Surg Proc V28	9680
793		N/A				9676
792	<=1	4/A/D	20			9602
792	<=1	N/A	20			9601
792	<=4	N/A	02/05			9604
792		N/A	20	5010 — 1000 — 1499 grams		9637
792		N/A	20	5009 — 750 — 999 grams		9620
792		N/A	20	5008 — Under 750 grams		9610
792		N/A		5012 — 2000 — 2500 grams	1032 — DRG or Surg Proc V28	9650
792		N/A		5012 — 2000 — 2500 grams		9657
792		N/A		5011 — 1500 — 1999 grams	1032 — DRG or Surg Proc V28	9648
792		N/A		5011 — 1500 — 1999 grams		9649
792		N/A		5010 — 1000 — 1499 grams	1032 — DRG or Surg Proc V28	9638
792		N/A		5010 — 1000 — 1499 grams		9639
792		N/A		5009 — 750 — 999 grams		9624
792		N/A		5008 — Under 750 grams		9614
792		N/A			1032 — DRG or Surg Proc V28	9680
792		N/A				9677
791	<=1	4/A/D			9602	
791	<=1	N/A	20			9601
791	<=4	N/A	02/05			9604
791		N/A	20	5010 — 1000 — 1499 grams		9637
791		N/A	20	5009 — 750 — 999 grams		9620
791		N/A	20	5008 — Under 750 grams		9610

791		N/A		5012 — 2000 — 2500 grams	1032 — DRG or Surg Proc V28	9650
791		N/A		5012 — 2000 — 2500 grams		9656
791		N/A		5011 — 1500 — 1999 grams	1032 — DRG or Surg Proc V28	9648
791		N/A		5011 — 1500 — 1999 grams		9649
791		N/A		5010 — 1000 — 1499 grams	1032 — DRG or Surg Proc V28	9638
791		N/A		5010 — 1000 — 1499 grams		9639
791		N/A		5009 — 750 — 999 grams		9624
791		N/A		5008 — Under 750 grams		9614
791		N/A			1032 — DRG or Surg Proc V28	9680
791		N/A				9676
790	<=1	4/A/D	20			9602
790	<=1	N/A	20			9601
790	<=4	N/A	02/05			9604
790		N/A	20	5010 — 1000 — 1499 grams		9637
790		N/A	20	5009 — 750 — 999 grams		9620
790		N/A	20	5008 — Under 750 grams		9610
790		N/A		5012 — 2000 — 2500 grams	1032 — DRG or Surg Proc V28	9650
790		N/A		5012 — 2000 — 2500 grams		9656
790		N/A		5011 — 1500 — 1999 grams	1032 — DRG or Surg Proc V28	9648
790		N/A		5011 — 1500 — 1999 grams		9649
790		N/A		5010 — 1000 — 1499 grams	1032 — DRG or Surg Proc V28	9638
790		N/A		5010 — 1000 — 1499 grams		9639
790		N/A		5009 — 750 — 999 grams		9624
790		N/A		5008 — Under 750 grams		9614

790		N/A			1032 — DRG or Surg Proc V28	9680
790		N/A				9676
789	<=1	4/A/D	20			9602
789	<=1	N/A	20			9601
789	<=4	N/A	02/05			9604
789		N/A	20	5010 — 1000 — 1499 grams		9637
789		N/A	20	5009 — 750 — 999 grams		9620
789		N/A	20	5008 — Under 750 grams		9610
789		N/A		5012 — 2000 — 2500 grams	1032 — DRG or Surg Proc V28	9650
789		N/A		5012 — 2000 — 2500 grams		9670
789		N/A		5011 — 1500 — 1999 grams	1032 — DRG or Surg Proc V28	9648
789		N/A		5011 — 1500 — 1999 grams		9649
789		N/A		5010 — 1000 — 1499 grams	1032 — DRG or Surg Proc V28	9638
789		N/A		5010 — 1000 — 1499 grams		9639
789		N/A		5009 — 750 — 999 grams		9624
789		N/A		5008 — Under 750 grams		9614
789		N/A			1032 — DRG or Surg Proc V28	9680
789		N/A				9678

Topic #1376

Payment Methods

The Hospital Inpatient and Outpatient State Plans are Wisconsin Medicaid's federally approved description of methods and standards for establishing payment rates to providers. The State Plans include all hospital inpatient and outpatient rate-setting methodologies. The State Plans are effective from July 1 to June 30. Wisconsin Medicaid amends the State Plans at least once each year. Hospitals are allowed an opportunity to comment on proposed amendments before Wisconsin Medicaid requests approval from the CMS (Centers for Medicare and Medicaid Services) for state plan changes. Providers may obtain copies of the state plan on the ForwardHealth Portal. The Inpatient Hospital State Plan includes the following information:

- Administrative adjustment actions.
- Border status hospital and cost reports.
- Disproportionate share.

- Hospital outlier trim points.
- Out-of-state, nonborder status inpatient hospital stays.

Topic #4385

Pharmacy Services and Some Drug-Related Supplies

Pharmacy services and some drug-related supplies for managed care members are reimbursed by fee-for-service.

The following provider-administered drugs and related administration codes are reimbursed by fee-for-service, not a member's MCO (managed care organization), for members enrolled in BadgerCare Plus HMOs, Medicaid SSI (Supplemental Security Income) HMOs, and most special managed care programs if the service is covered by BadgerCare Plus and Medicaid:

- All "J" codes.
- Drug-related "Q" codes.
- A limited number of related administration codes.

For members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, claims for these services should be submitted to BadgerCare Plus and Medicaid fee-for-service.

MCOs are responsible for reimbursing providers for all other provider-administered drugs, such as drug claims submitted with a CPT (Current Procedural Terminology) code, such as CPT code 90378 (Respiratory syncytial virus immune globulin [RSV-IgIM], for intramuscular use, 50 mg, each).

Prescription drugs and related services and provider-administered drugs for members enrolled in the PACE (Program of All-Inclusive Care for the Elderly) and the Family Care Partnership are provided and reimbursed by the special managed care program.

Claims

Claims for drug-related supplies should be submitted with the appropriate HCPCS (Healthcare Common Procedure Coding System) procedure code indicated.

Topic #1378

Retroactive Rate Adjustments

Wisconsin Medicaid automatically generates retroactive rate adjustments for any paid inpatient claim with dates of discharge on or after the effective date of a rate change back to the authorized effective date of the rate change. No additional action is required by the hospital to receive the rate adjustment.

For example: The legislature approves rate changes for dates of discharge on and after July 1, but does not finalize the change until September 1. In this case, Wisconsin Medicaid retroactively adjusts all paid claims with dates of discharge between July 1 and September 1. Both DRG (Diagnosis Related Group) payments and outliers are adjusted for the change.

Collecting Payment From Members

Topic #9577

Basic Plan Member Deductible for Inpatient and Outpatient Services

The Basic Plan member's deductible is $7,500.00 per enrollment year for all combined inpatient and outpatient hospital services. Providers should submit claims to ForwardHealth for all hospital services provided to Basic Plan members, regardless of whether the deductible is applied or not. This will ensure that all services provided to the member are applied to the member's deductible.

Inpatient Services

After the member's first inpatient hospital stay, each subsequent inpatient hospital stay will be applied to the member's deductible. During the deductible period, the member is only liable for the amount that Wisconsin Medicaid would have reimbursed the provider for the services. After the deductible is met, ForwardHealth will reimburse any additional inpatient hospital stays for the remainder of the enrollment year at the DRG base rate, excluding outlier costs and hospital access payments. Once the member has satisfied the deductible, no authorization is needed before providing inpatient hospital services.

Outpatient Services

After the member's first five outpatient hospital visits, each subsequent outpatient visit will be applied to the member's deductible. During the deductible period, the member is only liable for the amount that Wisconsin Medicaid would have reimbursed the provider for the services. After the member's deductible is met, ForwardHealth will reimburse any additional outpatient stays for the remainder of the enrollment year at the current Wisconsin Medicaid rate. Once the member has satisfied the deductible, no authorization is needed before providing outpatient hospital services.

Topic #4317

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 (physical therapy), OT (occupational therapy), and SLP (speech and language pathology)).

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 (durable medical equipment) 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.

Topic #227

Conditions That Must Be Met

A member may request a noncovered service, a covered service for which PA (prior authorization) 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.

Topic #538

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 from the member *only* the Medicaid or BadgerCare Plus copayment amount indicated on the member's remittance information.

Topic #4497

Patient Liability for Inpatient Hospital Providers

Patient liability amounts are deducted from long-term inpatient hospital claims (stays of 30 days or more). Patient liability is any member income in excess of the personal needs allowance and is used to cover the member's medical costs if they are institutionalized for 30 days or more. Providers should not indicate patient liability amounts on claim forms, since liability amounts are automatically deducted from claims.

Patient liability applies to services provided to members enrolled in Medicaid and does *not* apply for services provided to BadgerCare Plus Standard Plan members or Benchmark Plan Members.

ForwardHealth automatically deducts the appropriate monthly patient liability amount from the *first* nursing home, hospice, or long-term inpatient hospital claim received for the member. For example, a member is living in a nursing home for the month of November but is admitted into an inpatient hospital for the last two days of the month. Both the nursing home and the inpatient hospital submit a claim to ForwardHealth for that member for the month of November. ForwardHealth receives the claim from the inpatient hospital first, so the patient liability is deducted from that claim because it was the first claim received for that member, and from a case point of view, the member has 30 days in a facility. If the amount of patient liability exceeds the reimbursement amount of the first claim, the remaining liability amount will be deducted from the next claim(s) received for services provided in the month that patient liability is owed.

Patient liability amounts deducted from claims will appear in the providers' remittance information. Nursing home providers collect the full monthly liability amount from the patient. They should work with hospice providers and inpatient hospital providers to transfer the appropriate patient liability amount due to those providers.

If a paid claim is subsequently adjusted and denied, any liability amount originally deducted from the claim is returned to the member's patient liability balance on ForwardHealth interChange. Patient liability will be deducted from the next institutional claim paid for services provided in the month that patient liability is owed.

Retroactive Patient Liability Changes

If a member's patient liability decreases retroactively, ForwardHealth will change the member's file and adjust the paid claim as appropriate.

Topic #224

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 (prior authorization) 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 enrollment.

Copayment

Topic #1382

Amounts

Standard Plan and Medicaid

The copayment for inpatient hospital services is $3.00 per day (up to $75.00 per stay) for BadgerCare Plus Standard Plan and Medicaid members.

Benchmark Plan

Under the BadgerCare Plus Benchmark Plan, the following copayment amounts apply to inpatient hospital services:

- $100.00 per inpatient hospital stay, except for hospital stays for mental health or substance abuse treatment.
- $50.00 per inpatient hospital stay for mental health or substance abuse treatment. This copayment applies regardless of the type of hospital facility in which the stay occurred.

If a Benchmark Plan member receives services in an emergency room and is eventually admitted as an inpatient, copayment should only be charged for the inpatient hospital stay, but not for the emergency room visit.

Note: A physician's copayment is separate from an emergency room or inpatient copayment.

Core Plan

Copayments for hospital services covered under the BadgerCare Plus Core Plan vary depending on the type of service and the member's income level. Enrollment verification responses in the ForwardHealth Portal and Wisconsin's EVS (Enrollment Verification System) will tell providers if the member is part of the lower or higher income bracket by identifying the member as "BadgerCare Plus Core Plan 1" or "BadgerCare Plus Core Plan 2." Providers are required to use the following guidelines for collecting copayments for hospital services from Core Plan members:

- Core Plan 1 members have income up to and including 100 percent of the FPL (Federal Poverty Level) and should be charged the lower copayment amounts or exempted from copayment, as applicable.
- Core Plan 2 members have income above 100 percent FPL and up to 200 percent FPL and should be charged the higher copayment amounts.

For members with income up to and including 100 percent of the FPL (Core Plan 1 members), the copayment for inpatient hospital services is $3.00 per day, with a limit of $75.00 per hospital stay.

Copayment for all inpatient and outpatient hospital services for Core Plan 1 members is capped at $300.00 per member, per enrollment year.

For members with income above 100 percent FPL and up to 200 percent FPL (Core Plan 2 members), the copayment for inpatient hospital services is $100.00 per stay.

Copayment for all inpatient and outpatient hospital services for Core Plan 2 members is capped at $300.00 per member, per enrollment year.

Basic Plan

Inpatient hospital services under the Basic Plan have a $100.00 copayment for nondeductible stays.

Topic #231

Exemptions

Wisconsin Medicaid Exemptions

According to DHS 104.01(12), Wis. Admin. Code, providers are prohibited from collecting copayment from the following Wisconsin Medicaid members:

- Children in a mandatory coverage category. In Wisconsin, this includes:
  - Children in foster care, regardless of age.
  - Children in subsidized adoption, regardless of age.
  - Children in the Katie Beckett program, regardless of age.
  - Children under age one with income up to 150 percent of the FPL (Federal Poverty Level).
  - Children ages 1 through 5 with income up to 185 percent FPL.
  - Children ages 6 through 18 years of age with incomes at or below 100 percent of the FPL.
- Children who are American Indian or Alaska Natives who are enrolled in the state's CHIP (Child Health Insurance Program).
- American Indians or Alaskan Natives, regardless of age or income level, when they receive items and services either directly from an Indian health care provider or through referral under contract health services.
- Terminally-ill individuals receiving hospice care.
- Nursing home residents.

The following services do not require copayment:

- Case management services.
- Crisis intervention services.
- CSP (Community Support Program) services.
- Emergency services.
- Family planning services, including sterilizations.
- Home care services.
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- PDN (private duty nursing) and PDN services for ventilator-dependent members.
- SBS (school-based services).
- Substance abuse day treatment services.
- Surgical assistance.

BadgerCare Plus Standard Plan Exemptions

Providers are prohibited from collecting copayment from the following BadgerCare Plus Standard Plan members:

- Children in a mandatory coverage category. In Wisconsin, this includes:
  - Children in foster care, regardless of age.

    - Children in subsidized adoption, regardless of age.
    - Children in the Katie Beckett program, regardless of age.
    - Children under age one with income up to 150 percent of the FPL (Federal Poverty Level).
    - Children ages 1 through 5 with income up to 185 percent FPL.
    - Children ages 6 through 18 years of age with incomes at or below 100 percent of the FPL.
- Children who are American Indian or Alaska Natives who are enrolled in the state's CHIP (Child Health Insurance Program).
- American Indians or Alaskan Natives, regardless of age or income level, when they receive items and services either directly from an Indian health care provider or through referral under contract health services.
- Terminally-ill individuals receiving hospice care.
- Nursing home residents.

The following services do not require copayment:

- Case management services.
- Crisis intervention services.
- CSP services.
- Emergency services.
- Family planning services, including sterilizations.
- Home care services.
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- PDN and PDN services for ventilator-dependent members.
- SBS.
- Substance abuse day treatment services.
- Surgical assistance.

Wisconsin Well Woman Medicaid Exemptions

Providers are prohibited from collecting copayment from members who have been enrolled into WWWMA (Wisconsin Well Woman Medicaid) from the BadgerCare Plus Benchmark Plan or the BadgerCare Plus Core Plan for any Medicaid covered service.

Topic #4273

BadgerCare Plus Benchmark Plan Exemptions

Certain 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.

Providers should always use Wisconsin's EVS (Enrollment Verification System) to verify member enrollment and to check if the member is subject to a copayment.

The following services do not require copayment under the Benchmark Plan:

- Family planning services.
- Preventive services, including HealthCheck screenings.

Topic #233

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.

Resetting Copayment Limitations

Copayment amounts paid by a member enrolled in the BadgerCare Plus Benchmark Plan and the BadgerCare Plus Core Plan within their continuous 12-month enrollment year will reset in the following situations:

- A fee-for-service member is enrolled in an HMO (health maintenance organization).
- A member switches from one HMO to another HMO (only allowable within the first 90 days of Core Plan enrollment).
- A member is disenrolled from an HMO and moves to fee-for-service.

Note: When a member goes from fee-for-service into an HMO and subsequently moves back to fee-for-service, copayments will not be reset for the services that were received under the initial fee-for-service enrollment period.

Resetting copayment limitations does not change a member's Benchmark Plan enrollment year or a member's Core Plan enrollment year.

Topic #237

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.

Topic #239

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 member, BadgerCare Plus Core Plan member, or BadgerCare Plus Basic Plan member who fails to make a copayment.

Section 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.

Pay for Performance Initiative

Topic #13317

Hospital Pay for Performance Initiative

For SFY (state fiscal year) 2013 (from July 1, 2012, to June 30, 2013), there are two components to the hospital P4P (pay for performance) initiative:

- The Assessment P4P program (applies to acute, children's, and rehabilitation hospitals).
- The Withhold P4P program (applies to acute, children's, critical access, and psychiatric hospitals).

These two separate programs will run concurrently.

Assessment Pay for Performance Program

The DHS (Department of Health Services) reserves $5 million for Wisconsin acute care, children's, and rehabilitation hospitals that meet certain performance targets. This performance-based payment system is the Assessment P4P program.

Assessment Pay for Performance Program Measures

For MY 2013 (July 1, 2012, to June 30, 2013), the Assessment P4P program will include the following three measures:

- Perinatal measures:
  - Pre-birth steroids.
  - Forceps delivery.
  - Vacuum delivery.
  - C-section with labor.
  - C-section without labor.
  - Breastfeeding.
  - Infant composite.
- Discharge Instructions for Heart Failure (CheckPoint 11) (new to the Assessment P4P program for MY 2013): Hospitals are required to report the percent of heart failure patients discharged to home with written instructions to the patient or caregiver that address all of the following:
  - Activity level.
  - Diet.
  - Discharge medications.
  - Follow-up appointment.
  - Weight monitoring.
  - What to do if symptoms worsen.
- Patient experience of care: Hospitals are required to report 10 measures based on patient completion of the Hospital Consumer Assessment of HealthCare Providers and Systems Questionnaire (HCAHPS Survey).

The DHS will transfer the surgical infection prevention index and surgical care improvement and clot prevention measures from the Assessment P4P program to the Withhold P4P program for MY 2013. The flu vaccine for pneumonia patients measure is being retired and therefore will no longer be part of the Assessment P4P program.

Funding Distribution by Measure

The $5 million allocated by the DHS for the Assessment P4P program will be distributed as follows:

- $2 million will be evenly distributed to hospitals for scoring at or above the state average on the pre-birth steroids, breastfeeding, and infant composite measures.
- $1.5 million is available for scoring at or above the statewide average on the discharge instructions for heart failure measure.
- $1.5 million is available for scoring at or above the statewide average on the patient experience of care measure.

Data Source for Setting Baselines

The baselines for these three sets of measures will be based on the latest 12-month data available on CheckPoint as of June 30, 2012.

Withhold Pay for Performance Program

Beginning July 1, 2012 (SFY 2013), inpatient hospital claims with dates of discharge during MY 2013 (July 1, 2012, through June 30, 2013) and outpatient hospital claims with dates of service during MY 2013, will be subject to a 1.5 percent withholding on each payable inpatient and outpatient hospital claim amount. The 1.5 percent of the payable amount will be withheld after member cost sharing is deducted and before access payments are applied. The withheld amount will be redistributed at a later date to hospital providers who meet certain performance-based criteria.

The P4P withhold will be deducted from claims submitted for fee-for-service members enrolled in the following programs:

- Wisconsin Medicaid.
- The BadgerCare Plus Standard Plan.
- The BadgerCare Plus Benchmark Plan.
- The BadgerCare Plus Core Plan.

The P4P withhold will not be deducted from claims submitted for BadgerCare Plus Basic Plan members.

The following claims will be excluded from this withhold for MY 2013 (July 1, 2012, to June 30, 2013):

- Crossover claims.
- Claims from border status providers.
- Claims from out-of-state providers.

Hospitals enrolled as one of the following types will be excluded from this withhold:

- Border status.
- Out of state.
- Long term care, rehabilitation, and nursing facilities.

Note: The claim types and types of hospitals in or out of the scope of the P4P initiative may change in future measurement years.

Withhold Pay for Performance Program Measures

As part of the Withhold P4P program, the DHS will utilize data from multiple sources, including Hospital Compare and CheckPoint, for acute care, critical access, psychiatric, and children's hospitals. Various combinations and permutations of the following six measures will apply to different types of hospitals:

- Thirty-day hospital readmission.
- Mental health follow-up visit within 30 days of discharge for mental health inpatient care.
- Asthma care for children.
- Surgical infection prevention index.

- Initial antibiotic for community-acquired pneumonia.
- Health care provider influenza vaccination.

The hospital readmission rates and mental health follow-up visits will be calculated by the DHS using Wisconsin Medicaid's claims data. Performance on the other measures will be evaluated based on data submitted to Hospital Compare, CheckPoint, or the DHS Division of Public Health. If a hospital does not report data for a particular measure, it will forfeit its withhold for that measure and will not be eligible for any bonus. The DHS reserves the right to verify a hospital's reported data using DHS's Medicaid claim data.

Targets for Withhold Pay for Performance Measures

For the thirty-day hospital readmission and mental health follow-up visit measures, hospitals will be evaluated on their level of improvement from their baselines. The DHS calculated the preliminary baselines using calendar year 2010 data and shared them with hospitals in April 2012. Based on hospital feedback on the preliminary baselines, the DHS is reviewing the baseline data and will share revised individual baselines and seek a second round of feedback from the hospitals via the secure Provider area of the ForwardHealth Portal in June 2012. The DHS plans to provide final baselines to individual hospitals via the Portal in August 2012.

Note: Although the targets for these two measures will be finalized in August 2012, the Withhold P4P program's MY 2013 will begin on July 1, 2012.

The target for the asthma care for children measure will be set at the national average as calculated by The Joint Commission. The targets for the surgical infection prevention index and initial antibiotic for community-acquired pneumonia will be set at the statewide average. The statewide average will be based on the latest 12-month data available on CheckPoint as of June 30, 2012.

The health care personnel influenza vaccination measure will be a Pay for Reporting measure in MY 2013 (July 1, 2012, to June 30, 2013). Therefore, any hospital that submits the Healthcare Personnel Influenza Vaccination Survey and has submitted a signed data release consent form will be deemed to have met the target for this measure.

Response to Baseline Reports

The DHS will share with hospitals (via the Portal) each hospital's individual baseline report for the 30-day hospital readmission and mental health follow-up measures. Hospitals can view and download the baseline report from their secure Provider page of the Portal. Providers will receive a secure provider Portal message when new reports are available for review. If the DHS does not have data on either the readmissions or the mental health follow-up measures, the hospital will not receive a baseline report for that particular measure.

Note: Even though a hospital may not receive a baseline report for a particular measure, that measure could still apply to the hospital if the hospital has sufficient observations for MY 2013.

Hospital providers with questions or concerns about their baseline reports should complete the following steps:

- Send an e-mail to *dhshospitalp4p@wisconsin.gov* outlining their intent to respond to the reports and a description of any identified discrepancies.
- Submit the supporting data related to the identified discrepancies via the secure Provider area of the Portal. The format for submitting data discrepancies will be provided by the DHS as part of the preliminary baseline reports.

If there are no discrepancies between the preliminary baseline reports and a hospital's data, no response is required. If a hospital does not respond to the baseline reports, the DHS will assume that the hospital agrees with the data contained in the report, and that data will be used to set the P4P targets for the MY.

Note: All communication involving sensitive data, including individually identifiable health information (known as PHI (protected

health information)), must be submitted via the secure Provider area of the Portal. Protected health information may include things such as the member's name combined with his/her identification number or Social Security number.

The DHS will review all questions/discrepancies related to the baseline reports submitted by hospitals and will respond to each inquiry via the secure Provider area of the Portal.

Reporting Deadlines and Payment Distribution

During each quarter of the MY, the DHS will distribute two reports to individual hospitals via the hospital's secure Provider page of the Portal. The reports will include cumulative information from the beginning of the MY on the following:

- The numerator, denominator, and member-level details for the thirty-day hospital readmissions measure.
- The numerator, denominator, and member-level details for the mental health follow-up visit measure.

Providers will receive a secure Provider Portal message when new reports are available for review.

Due to time lag associated with hospital claim submissions, these reports will not have up-to-date information, are for informational purposes only, and the DHS will not review any potential data discrepancies between hospital data and the data contained in these reports until the conclusion of MY 2013.

In the fourth quarter of calendar year 2013, the DHS will post preliminary MY 2013 results for the thirty-day hospital readmissions and mental health follow-up visit measures to the secure Provider page of the Portal. If a hospital believes there is a discrepancy between its data and its preliminary MY 2013 results, the hospital should notify the DHS via the secure Provider area of the Portal.

Note: The DHS will provide an annual report for the individual hospital performance and the total money withheld only after the completion of MY 2013 and after any applicable adjustments have been made. Hospitals will have the ability to determine the withheld amount during the MY by reviewing the RA (Remittance Advice) for each claim. In addition, claims where the P4P withhold has been applied will have the EOB code 9008 (Pricing Adjustment — Payment amount decreased based on Pay for Performance policy).

Assessment Pay for Performance Program Reporting Deadlines

Performance on Assessment P4P program measures will be based on the latest 12-month data available on CheckPoint as of November 30, 2013.

Withhold Pay for Performance Program Reporting Deadlines

The deadline for claims to be included in the Withhold P4P program performance evaluation is October 31, 2013. For payment purposes, hospitals have 365 days past the date of service to submit claims.

Note: Claims for services rendered during MY 2013 submitted after the October 31, 2013, deadline will still be subject to the 1.5 percent withhold.

Data Analysis and Payment Distribution

The reconciliation of financial and performance measurement data will occur on an annual basis. Beginning in the fourth quarter of calendar year 2013, the DHS will conduct internal analysis and, if necessary, will work with individual hospitals to reconcile any data discrepancies. The DHS intends to complete analysis for the Assessment P4P program by December 31, 2013, and for the Withhold P4P program in the first quarter of calendar year 2014.

Assessment P4P program payments will be made prior to December 31, 2013. Withhold P4P program payments will be made some time in the first quarter of 2014.

Portal Access and Roles

In order to access P4P baseline reports, to submit responses, and to access the Hospital P4P Guide on the secure Portal, staff must be either the Portal Administrator for the facility or a Clerk assigned the role of "Hospital P4P."

For more information on adding Clerks and Clerk roles, refer to the ForwardHealth Provider Portal Account User Guide available on the Portal User Guides page of the Portal.

Once a Clerk's "Hospital P4P" role has been assigned, the P4P information can be accessed by logging in to the secure Provider area of the Portal and clicking the "Hospital Pay for Performance" link in the Quick Links box.

Questions Regarding the Pay for Performance Initiative

Hospital providers may submit questions regarding specific measures or methodology for the P4P initiative to ForwardHealth at *dhshospitalp4p@wisconsin.gov*. All communication involving the transmission of sensitive data, such as PHI, must be submitted via the secure Portal.

For additional information regarding the Assessment P4P program or the Withhold P4P program, including measure specifications, program/bonus methodology, and a frequently-asked-questions section, refer to the Hospital P4P Guide.

Payer of Last Resort

Topic #242

Instances When Medicaid Is Not Payer of Last Resort

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

- Birth to 3.
- Crime Victim Compensation Fund.
- GA (General Assistance).
- HCBS (Home and Community-Based Services) waiver programs.
- IDEA (Individuals with Disabilities Education Act).
- Indian Health Service.
- Maternal and Child Health Services.
- WCDP (Wisconsin Chronic Disease Program).
    - Adult Cystic Fibrosis.
    - Chronic Renal Disease.
    - Hemophilia Home Care.

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

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

Topic #251

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 (Civilian Health and Medical Plan of the Veterans Administration).
- Other governmental benefits.

Topic #253

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 (managed care organization).

Topic #255

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

Topic #1375

Institution for Mental Disease Services for Persons 21 to 64 Years of Age

In accordance with DHS 107.03(15), Wis. Admin. Code, Wisconsin Medicaid does not reimburse expenditures for any service to a person 21 to 64 years of age who is a resident of an IMD (institution for mental disease), unless one of the following exceptions are met:

- The member was a resident of the IMD immediately prior to turning 21, and has been continuously a resident up to his or her 22nd birthday.
- The member was on convalescent leave from an IMD.

A member who is a resident of an IMD and is 21 years of age may be covered only until his or her 22nd birthday.

Topic #1374

Reimbursement Not Available

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

Under DHS 107.08(4), Wis. Admin. Code, the following are not reimbursable as inpatient hospital services:

- Unnecessary or inappropriate inpatient admissions or portions of a stay.
- Hospitalizations or portions of hospitalizations identified by the ERO (External Review Organization) for disallowance of reimbursement by Wisconsin Medicaid.
- Hospitalizations either for or resulting in surgeries which Wisconsin Medicaid considers experimental due to questionable or unproven medical effectiveness.
- Inpatient and outpatient services for the same recipient on the same date of service, unless the member is admitted to a hospital other than the facility providing the outpatient care.
- Hospital admissions on Friday or Saturday, except for emergencies, accident or accident care, and obstetrical cases, unless the hospital can demonstrate to the satisfaction of Wisconsin Medicaid that the hospital provides all its services seven days a week.
- Hospital laboratory, diagnostic, radiology, and imaging tests not ordered by a physician, except in emergencies.

Topic #695

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.

Topic #51

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 (durable medical equipment) delivery charges are included in the reimbursement for DME items.

Resources

10

Archive Date:01/02/2013

Resources:Contact Information

Topic #476

Member Services

Providers should refer ForwardHealth members with questions to Member Services. The telephone number for Member Services is for member use only.

Topic #473

Provider Relations Representatives

The Provider Relations representatives, also known as field representatives, conduct training sessions on various ForwardHealth topics for both large and small groups of providers and billers. In addition to provider education, field representatives are available to assist providers with complex billing and claims processing questions. Field representatives are located throughout the state to offer detailed assistance to all ForwardHealth providers and all ForwardHealth programs.

Field Representative Specialization

The field representatives are assigned to specific regions of the state. In addition, the field representatives have specialized in a group of provider types. This specialization allows the field representatives to most efficiently and effectively address provider inquiries. To better direct inquiries, providers should contact the field representative in their region who specializes in their provider type.

Provider Education

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

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

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

Additional Inquiries

Providers are encouraged to initially obtain information through the 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.
- PES (Provider Electronic Solutions) claims submission software.
- Claims processing problems that have not been resolved through other channels (e.g., telephone or written

correspondence).
- Referrals by a Provider Services telephone correspondent.
- Complex issues that require 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.

If contacting a field representative by e-mail, providers should ensure that no individually identifiable health information, known as PHI (protected health information), is included in the message. PHI can include things such as the member's name combined with his/her identification number or SSN (Social Security number).

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 (National Provider Identifier) 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 (date of service).

Topic #474

Provider Services

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

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

Ways Provider Services Can Help

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

- Billing and claim submissions.
- Provider enrollment.
- COB (coordination of benefits) (e.g., verifying a member's other health insurance coverage).
- Assistance with completing forms.
- Assistance with remittance information and claim denials.
- Policy clarification.

- PA (prior authorization) status.
- Verifying covered services.

Information to Have Ready

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

- Provider name and NPI or provider ID.
- Member name and member identification number.
- Claim number.
- PA number.
- DOS (dates of service).
- Amount billed.
- RA (Remittance Advice).
- Procedure code of the service in question.
- Reference to any provider publications that address the inquiry.

Call Center 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 (Specialized Transmission Approval Technology-Prior Authorization) for STAT-PA inquiries, including inquiries from pharmacies, DME (durable medical equipment) 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 (end-stage renal disease), and hospice services or NIP (nurses in independent practice)).
- 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 (F-01170 (07/12)) form. The Written Correspondence Inquiry form may be photocopied or downloaded via a link from the Portal. Written correspondence should be sent to the following address:

ForwardHealth
Provider Services Written Correspondence
313 Blettner Blvd
Madison WI 53784

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

Topic #475

Provider Suggestions

The DHCAA (Division of Health Care Access and Accountability) 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 (F-1016 (02/09)) form.

Topic #4456

Resources Reference Guide

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

Provider Services and Resources

Services and resources, contact information, and hours of availability are effective after ForwardHealth implementation, unless otherwise noted.

ForwardHealth Portal	***www.forwardhealth.wi.gov/***	**24 hours a day, seven days a week**
Public and secure access to ForwardHealth information with direct link to contact Provider Services for up-to-date access to ForwardHealth programs information, including publications, fee schedules, and forms.		
WiCall Automated Voice Response System	**(800) 947-3544**	**24 hours a day, seven days a week**
WiCall, the ForwardHealth Automated Voice Response system, provides responses to the following inquiries: • Checkwrite. • Claim status. • Prior authorization. • Member enrollment.		
ForwardHealth Provider Services Call Center	**(800) 947-9627**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Time)***
To assist providers in the following programs: • BadgerCare Plus. • Medicaid. • SeniorCare. • Wisconsin Well Woman Medicaid. • Wisconsin Chronic Disease Program (WCDP). • Wisconsin Well Woman Program (WWWP). • Wisconsin Medicaid and BadgerCare Plus Managed Care Programs.		
ForwardHealth Portal Helpdesk	**(866) 908-1363**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Time)***
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal accounts, registrations, passwords, and submissions through the Portal.		
Electronic Data Interchange Helpdesk	**(866) 416-4979**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Time)***
For providers, trading partners, billing services, and clearing houses with technical questions about the following: • Electronic transactions. • Companion documents. • Provider Electronic Solutions (PES) software.		
Managed Care Ombudsman Program	**(800) 760-0001**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Time)***
To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.		
Member Services	**(800) 362-3002**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Time)***
To assist ForwardHealth members or persons calling on behalf of members with program information and requirements, enrollment, finding certified providers, and resolving concerns.		

* With the exception of state-observed holidays.

Electronic Data Interchange

Topic #459

Companion Guides and NCPDP Version D.0 Payer Sheet

Companion guides and the NCPDP (National Council for Prescription Drug Programs) version D.0 payer sheet are available for download on the ForwardHealth Portal.

Purpose of Companion Guides

ForwardHealth companion guides and payer sheet provide trading partners with useful technical information on ForwardHealth's standards for nationally recognized electronic transactions.

The information in companion guides and payer sheet applies to BadgerCare Plus, Medicaid, SeniorCare, WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program). Companion guides and payer sheet are intended for information technology and systems staff who code billing systems or software.

The companion guides and payer sheet complement the federal HIPAA (Health Insurance Portability and Accountability Act of 1996) 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 (Remittance Advice), and enrollment inquiries).

Companion guides and payer sheet do *not* include program requirements, but help those who create the electronic formats for electronic data exchange.

Companion guides and payer sheet 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 (Electronic Data Interchange) Helpdesk.
- Transaction formats.

Revisions to Companion Guides and Payer Sheet

Companion guides and payer sheet may be updated as a result of changes to federal requirements. When this occurs, ForwardHealth will do the following:

- Post the revised companion guides and payer sheet 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 revised companion guides and payer sheet on the Portal. If trading partners do not follow the revisions identified in the companion guides or payer sheet, transactions may not process successfully (e.g., claims may deny or process incorrectly).

A change summary located at the end of the revised companion guide lists the changes that have been made. The date on the

companion guide reflects the date the revised companion guide was posted to the Portal. In addition, the version number located in the footer of the first page is changed with each revision.

Revisions to the payer sheet are listed in Appendix A. The date on the payer sheet reflects the date the revised payer sheet was posted to the Portal.

Topic #460

Data Exchange Methods

The following data exchange methods are supported by the EDI (Electronic Data Interchange) Helpdesk:

- 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 (National Council for Prescription Drug Programs) D.0, 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response), 276/277 (276/277 Health Care Claim Status Request and Response), or 278 (278 Health Care Services Review — Request for Review and Response) transactions via an approved clearinghouse.

The EDI Helpdesk supports the exchange of the transactions for BadgerCare Plus, Medicaid, SeniorCare, WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program).

Topic #461

Electronic Data Interchange Helpdesk

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

Providers with policy questions should call Provider Services.

Topic #462

Electronic Transactions

HIPAA (Health Insurance Portability and Accountability Act of 1996) ASC (Accredited Standards Committee) X12 version 5010 companion guides and the NCPDP (National Council for Prescription Drug Programs) version D.0 payer sheet are available for download on the HIPAA Version 5010 Companion Guides and NCPDP Version D.0 Payer Sheet page of the ForwardHealth Portal.

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 (Electronic Data Interchange) Helpdesk, trading partners may exchange the following electronic transactions:

- 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response). The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.
- 276/277 (276/277 Health Care Claim Status Request and Response). The 276 is the electronic transaction for checking

claim status. The 277 is received in response.
- 278 (278 Health Care Services Review - Request for Review and Response). The electronic transaction for health care service PA (prior authorization) requests.
- 835 (835 Health Care Claim Payment/Advice). The electronic transaction for receiving remittance information.
- 837 (837 Health Care Claim). The electronic transaction for submitting claims and adjustment requests.
- 999 (999 Functional Acknowledgment). 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 D.0 Telecommunication Standard for Retail Pharmacy Claims. The real-time POS (Point-of-Sale) electronic transaction for submitting pharmacy claims.

Topic #463

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. PES (Provider Electronic Solutions) software allows providers to submit 837 (837 Health Care Claim) transactions and download the 999 (999 Functional Acknowledgment) and the 835 (835 Health Care Claim Payment/Advice) transactions. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Topic #464

Trading Partner Profile

A Trading Partner Profile 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 Trading Partner Profile.

To determine whether a Trading Partner Profile 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 (Provider Electronic Solutions) software, are required to complete the Trading Partner Profile.
- Billing providers who use a third party (billing services and clearinghouses) to exchange electronic transactions are required to submit a Trading Partner Profile.
- 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 Trading Partner Profile.

Providers who change billing services and clearinghouses or become a trading partner should keep their information updated by contacting the EDI (Electronic Data Interchange) Helpdesk.

Topic #465

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

Topic #256

270/271 Transactions

The 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response) transactions allow for batch enrollment verification, including information for the current benefit month or for any date of eligibility the member has on file, 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 (National Provider Identifier), 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 enrollment 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 enrollment on file with ForwardHealth. The 271 response will report the provider ID that was indicated on the 270.

Topic #469

An Overview

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

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

Topic #259

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 (Enrollment Verification System) 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.

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 (date of service) 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.

Topic #4903

Copayment Information

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

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

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

Note: The BadgerCare Plus Core Plan may also charge different copayments for hospital services depending on the member's income level. Members identified as "BadgerCare Plus Core Plan 1" are subject to lower copayments for hospital services. Members identified as "BadgerCare Plus Core Plan 2" are subject to higher copayments for hospital services.

Topic #264

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 (Enrollment Verification System) to receive the most current enrollment information through the following methods:

- ForwardHealth Portal.
- WiCall, Wisconsin's AVR (Automated Voice Response) system.
- Commercial enrollment verification vendors.
- 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Response) 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.

Topic #4901

Enrollment Verification on the Portal

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

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

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

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

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

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

Topic #4900

Entering Dates of Service

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

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

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

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

Topic #265

Member Forgets ForwardHealth Identification Card

Even if a member does not present a ForwardHealth identification card, a provider can use Wisconsin's EVS (Enrollment Verification System) 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 (Social Security number) 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.

Topic #4899

Member Identification Card Does Not Guarantee Enrollment

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

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

Topic #4898

Responses Are Based on Financial Payer

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

There are three financial payers under ForwardHealth:

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

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

Forms

Topic #767

An Overview

ForwardHealth requires providers to use a variety of forms for PA (prior authorization), claims processing, and documenting special circumstances.

Topic #470

Fillable Forms

Most forms may be obtained from the Forms page of the ForwardHealth Portal.

Forms on the Portal are available as fillable PDF (Portable Document Format) 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.

Topic #766

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
    313 Blettner Blvd
    Madison WI 53784

Portal

Topic #4904

Claims and Adjustments Using the ForwardHealth Portal

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

Providers can submit an individual claim or adjust a claim through DDE (Direct Data Entry) through the secure Portal.

Topic #8524

Conducting Revalidation Via the ForwardHealth Portal

Providers can conduct revalidation online via a secure revalidation area of the ForwardHealth Portal.

Topic #5157

Cost Share Reports for Long-Term Managed Care Organizations

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

Topic #4345

Creating a Provider Account

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

1. Go to the ForwardHealth Portal.
2. Click the **Providers** button.
3. Click **Logging in for the first time?**.
4. Enter the Login ID and PIN. The Login ID is the provider's NPI or provider number.
5. Click **Setup Account**.
6. At the Account Setup screen, enter the user's information in the required fields.

7. Read the security agreement and click the checkbox to indicate agreement with its contents.
8. Click **Submit** when complete.

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

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

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

Topic #9597

Deductible Status and Authorization Requests for Basic Plan Members

Providers have access to two features on the secure provider Portal regarding Basic Plan member deductible information, authorization inquiries and authorization requests.

The first feature allows providers to search for member information by entering the member's identification number, and the provider is able to view the Basic Plan information for the current year and the prior year, if applicable. The following information will display if the inquiry is successful:

- The dates that deductibles were applied towards the member's deductible balance and the amounts of each deductible paid. The beginning balance and the remaining balance will both display, based on claims submitted to ForwardHealth to-date.
- The number of member authorizations used, if any, and any authorizations that were requested by the provider performing the inquiry.

The second feature is an authorization request page that allows providers to request a new Basic Plan authorization for the member. If the request is successful, the provider will receive an authorization tracking number for their records.

Topic #4340

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

Providers must designate a trading partner to receive their 835 (835 Health Care Claim Payment/Advice) transaction for ForwardHealth interChange.

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

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

- Access the Portal and log into their secure account by clicking the Provider link/button.
- Click on the Designate 835 Receiver link on the right-hand side of the secure home page.

- Enter the identification number of the trading partner that is to receive the 835 in the Trading Partner ID field.
- Click Save.

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

Topic #5087

Electronic Communications

The secure ForwardHealth 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.

Topic #5088

Enrollment Verification

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

- The health care program(s) in which the member is enrolled.
- Whether or not the member is enrolled in a state-contracted MCO (managed care organization).
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance.
- Whether or not the member is enrolled in the Pharmacy Services Lock-In Program and the member's Lock-In pharmacy, primary care provider, and referral providers (if applicable).

Using the Portal to check enrollment may be more effective than calling WiCall or the EVS (Enrollment Verification System) (although both are available).

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

Topic #4338

ForwardHealth Portal

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

The Portal has the following areas:

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

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

Topic #4441

ForwardHealth Portal Helpdesk

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

Topic #4451

Inquiries to ForwardHealth Via the Portal

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

Topic #4400

Internet Connection Speed

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

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

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

Topic #4351

Logging in to the Provider Area of the Portal

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

Topic #4743

Managed Care Organization Portal

Information and Functions Through the Portal

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

The following information is available through the Portal:

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

Topic #5158

Managed Care Organization Portal Reports

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

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

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

Capitation Payment Listing Report

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

Initial Enrollment Roster Report

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

Final Enrollment Roster Report

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

Other Reports

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

Topic #4744

Members ForwardHealth Portal

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

Topic #4344

Obtaining a Personal Identification Number

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

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

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

Providers may request a PIN by following these steps:

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

        The financial payer is one of the following:
        - Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and Senior Care).
        - SSI (Supplemental Security Income).
        - WCDP (Wisconsin Chronic Disease Program).
        - The WWWP (Wisconsin Well Woman Program).

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

Topic #4459

Online Handbook

The Online Handbook allows providers access to all policy and billing information for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and WCDP (Wisconsin Chronic Disease Program) 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 links to the ForwardHealth Publications page, an archive section that providers can use to research past policy and procedure information.

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 sections and chapters. Sections within each handbook may include the following:

- Claims.
- Coordination of Benefits.
- Managed Care.
- Member Information.
- Prior Authorization.
- Provider Enrollment and Ongoing Responsibilities.
- 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.

ForwardHealth Publications Archive Area

The ForwardHealth Publications page 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. Click on the "Updates and Handbooks" link. (This link is below the three drop-down menus.)

Topic #5089

Other Business Enhancements Available on the Portal

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

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

Topic #4911

Portal Account Administrators

Portal administrators are responsible for requesting, creating, and managing accounts to access these features for their organization.

There must be one administrator assigned for each Portal account and all users established for that account. The responsibilities of the Portal administrator include:

- Ensuring the security and integrity of all user accounts (clerk administrators and clerks) created and associated with their Portal account.
- Ensuring clerks or clerk administrators are given the appropriate authorizations they need to perform their functions for the provider, trading partner, or MCO (managed care organization).
- Ensuring that clerks or clerk administrator accounts are removed/deleted promptly when the user leaves the organization.
- Ensuring that the transactions submitted are valid and recognized by ForwardHealth.
- Ensuring that all users they establish know and follow security and guidelines as required by HIPAA (Health Insurance Portability Accountability Act of 1996). As Portal administrators establish their Portal account and create accounts for others to access private information, administrators are reminded that all users must comply with HIPAA. The HIPAA privacy and security rules require that the confidentiality, integrity, and availability of PHI (protected health information) are maintained at all times. The HIPAA Privacy Rule provides guidelines governing the disclosure of PHI. The HIPAA Security Rule delineates the security measures to be implemented for the protection of electronic PHI. If Portal administrators have any questions concerning the protection of PHI, visit the Portal for additional information.

Portal administrators have access to all secure functions for their Portal account.

Establish an Administrator Account

All Portal accounts require an administrator account. The administrator is a selected individual who has overall responsibility for management of the account. Therefore, he or she has complete access to all functions within the specific secure area of his or her Portal and are permitted to add, remove, and manage other individual roles.

Topic #4912

Portal Clerk Administrators

A Portal administrator may choose to delegate some of the authority and responsibility for setting up and managing the users within their ForwardHealth Portal account. If so, the Portal administrator may establish a clerk administrator. An administrator or clerk administrator can create, modify, manage or remove clerks for a Portal account. When a clerk is created, the administrator or clerk administrator must grant permissions to the clerks to ensure they have the appropriate access to the functions they will perform. A clerk administrator can only grant permissions that they themselves have. For example, if an administrator gives a clerk administrator permission only for enrollment verification, then the clerk administrator can only establish clerks with enrollment verification permissions.

Even if a Portal administrator chooses to create a clerk administrator and delegate the ability to add, modify, and remove users from the same account, the Portal administrator is still responsible for ensuring the integrity and security of the Portal account.

Topic #4913

Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their ForwardHealth Portal account. Clerks may be assigned one or many roles (i.e., claims, PA (prior authorization), member enrollment verification). Clerks do not have the ability to establish, modify, or remove other accounts.

Once a clerk account is set up, the clerk account does not have to be established again for a separate Portal account. Clerks can easily be assigned a role for different Portal accounts (i.e., different ForwardHealth enrollments). To perform work under a different Portal account for which they have been granted authorization, a clerk can use the "switch org" function and toggle between the Portal accounts to which they have access. Clerks may be granted different authorization in each Portal account (i.e., they may do member enrollment verification for one Portal account, and HealthCheck inquires for another).

Topic #4740

Public Area of the Provider Portal

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

Maximum Allowable Fee Schedules

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

Online Handbook

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

Revisions to policy information are incorporated into the Online Handbook in conjunction with published *Updates*. The Online Handbook also links to the ForwardHealth Publications page, an archive section where providers can research previously published *Updates*.

ForwardHealth Publications Archive Section

The ForwardHealth Publications page, available via the Quick Links box, lists *Updates*, *Update Summaries*, archives of provider Handbooks and provider guides, and monthly archives of the Online Handbook. The ForwardHealth Publications page contains both current and obsolete information for research purposes only. Providers should use the Online Handbook for current policy and procedure questions. The *Updates* are searchable by provider type or program (e.g., physician or HealthCheck "Other Services") and by year of publication.

Training

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

Contacting Provider Services

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

Online Enrollment

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

Other Business Enhancements Available on the Portal

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

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

Topic #4741

Secure Area of the Provider Portal

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

Claims and Adjustments Using the Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, and determine what

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

Providers can submit an individual claim or adjust a claim via DDE (Direct Data Entry) through the secure Portal.

Submitting Prior Authorization and Amendment Requests Via the Portal

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

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

Electronic Communications

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

Enrollment Verification

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

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

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

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

Other Business Enhancements Available on the Portal

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

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

Topic #4905

Submitting Prior Authorization and Amendment Requests Via the Portal

Nearly all service areas can submit PA (prior authorization) requests 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 PAs 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.

Topic #4401

System and Browser Requirements

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

Recommended System Requirements	Recommended Browser Requirements
Windows-Based Systems	
Computer with at least a 500Mhz processor, 256 MB of RAM, and 100MB of free disk space	Microsoft Internet Explorer v. 6.0 or higher, or 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	

Topic #4742

Trading Partner Portal

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

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

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

Trading partners using PES should be sure to enter the Web logon and Web password associated with the ForwardHealth trading partner ID that will be used on PES transactions. Prior to submitting transactions through PES, trading partners must also make

sure their trading partner account is entered as the "Default Provider ID" on the Switch Organization page of the secure Trading Partner account on the Portal.

Training Opportunities

Topic #12757

Training Opportunities

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

On-Site Sessions

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

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

Online (Real-Time, Web-Based) Sessions

Online (real-time, Web-based) training sessions are available and are facilitated through HP® Virtual Room. Virtual Room sessions are offered on many of the same topics as on-site sessions, but online sessions offer the following advantages:

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

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

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

Recorded Webcasts

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

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

Notification of Training Opportunities

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

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

Updates

Topic #4460

Full Text Publications Available

Providers may request full-text versions of *ForwardHealth Updates* to be mailed to them by calling Provider Services.

Topic #478

General Information

ForwardHealth Updates are the first source of provider information. *Updates* announce the latest information on policy and coverage changes, PA (prior authorization) submission requirements, claims submission requirements, and training announcements.

The *ForwardHealth Update Summary* is posted to the ForwardHealth Portal on a monthly basis and contains an overview of *Updates* published that month. Providers with a ForwardHealth Portal account are notified through their Portal message box when the *Update Summary* is available on the Portal.

Updates included in the *Update Summary* are posted in their entirety on the Provider area of the Portal. Providers may access Updates from direct links in the electronic *Update Summary* as well as navigate to other Medicaid iinformation 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.

Revisions to policy information are incorporated into the Online Handbook in conjunction with published *Updates*. The Online Handbook also includes a link to the ForwardHealth Publications page, an archive section where providers can research previously published *Updates*.

Topic #4458

Multiple Ways to Access ForwardHealth Publications

Users may register for 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.

E-mail Subscription Service

Providers and other interested parties may register for e-mail subscription 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 (Wisconsin Chronic Disease Program)) and provider type (e.g., physician, hospital, DME (durable medical equipment) 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.

Users may sign up for an e-mail subscription by following these steps:

1. Click the Providers link on the ForwardHealth Portal.
2. In the Quick Links section on the right side of the screen, click Register for E-mail Subscription.
3. The Subscriptions page will be displayed. In the E-Mail field in the New Subscriber section, enter the e-mail address to which messages should be sent.
4. Enter the e-mail address again in the Confirm E-Mail field.
5. Click Register. A message will be displayed at the top of the Subscriptions page indicating the registration was successful. If there are any problems with the registration, an error message will be displayed instead.
6. Once registration is complete, click the program for which you want to receive messages in the Available Subscriptions section of the Subscriptions page. The selected program will expand and a list of service areas will be displayed.
7. Select the service area(s) for which you want to receive messages. Click Select All if you want to receive messages for all service areas.
8. When service area selection is complete, click Save at the bottom of the page.
9. The selected subscriptions will load and a confirmation message will appear at the top of the page.

WiCall

Topic #257

Enrollment Inquiries

WiCall is an AVR (Automated Voice Response) system that allows providers with touch-tone telephones direct access to enrollment information.

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 (date of service) 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 (Health Personnel Shortage Area) on the DOS or within the DOS range selected, HPSA information will be given.
- MCO (managed care organization): 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 the Pharmacy Services Lock-In Program 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.

Topic #6257

Entering Letters into WiCall

For some WiCall inquries, health care providers are required to enter their taxonomy code with their NPI (National Provider Identifier). Because taxonomy codes are a combination of numbers and letters, telephone key pad combinations, shown in the table below, allow providers to successfully enter taxonomy code letters for WiCall functions (e.g., press *21 to enter an "A," press *72 to enter an "R").

Letter	Key Combination	Letter	Key Combination
A	*21	N	*62
B	*22	O	*63
C	*23	P	*71
D	*31	Q	*11
E	*32	R	*72
F	*33	S	*73
G	*41	T	*81
H	*42	U	*82
I	*43	V	*83
J	*51	W	*91
K	*52	X	*92
L	*53	Y	*93
M	*61	Z	*12

Additionally, providers may select option 9 and press "#" for an automated voice explanation of how to enter letters in WiCall.

Topic #466

Information Available Via WiCall

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

- Claim status.
- Enrollment verification.
- PA (prior authorization) status.
- Provider CheckWrite information.

Note: ForwardHealth releases CheckWrite information to WiCall no sooner than on the first state business day following the financial cycle.

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

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

- Repeat the information.
- Make another inquiry of the same type.
- Return to the main menu.

- Repeat the options.

Claim Status

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

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

Enrollment Verification

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

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

Prior Authorization Status

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

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

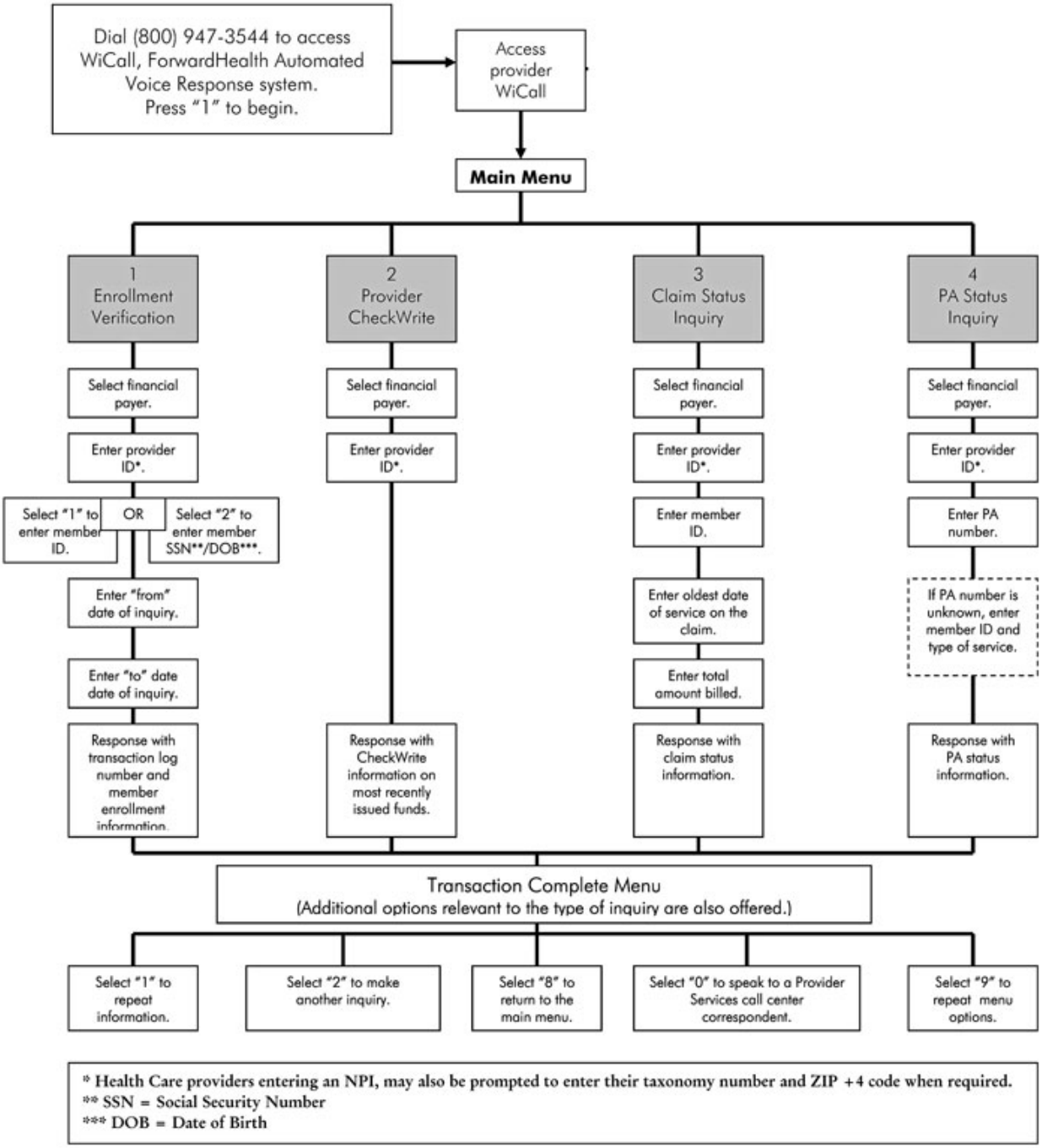
Note: PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Topic #765

Quick Reference Guide

The WiCall AVR (Automated Voice Response) Quick Reference Guide displays the information available for WiCall inquiries.

Automated Voice Response Quick Reference Guide



* Health Care providers entering an NPI, may also be prompted to enter their taxonomy number and ZIP +4 code when required.
** SSN = Social Security Number
*** DOB = Date of Birth