Claims

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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 Wisconsin DHS (Department of Health Services) 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 the claim is found, the provider can alter it to reflect the desired change and resubmit it to ForwardHealth. Any claim ForwardHealth has paid within 365 days of the DOS (date of service) can be adjusted and resubmitted on the Portal, regardless of how the claim was originally submitted.

Claim adjustments with DOS beyond the 365-day submission deadline should *not* be submitted electronically. Providers who attempt to submit a claim adjustment electronically for DOS beyond 365 days will have the entire amount of the claim recouped.

Requests for adjustments to claims with DOS beyond the 365-day submission deadline may be submitted using the timely filing process (a paper process) if the claim adjustment meets one of the exceptions to the claim submission deadline.

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 (08/15)) 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 #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 of Good Faith Claims

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 identification card for BadgerCare Plus or Family Planning Only Services, the provider should check the member's enrollment via Wisconsin's EVS (Enrollment Verification System) and, if the enrollment is not on file yet, make a photocopy of the member's temporary identification card.

When a member presents a temporary ID card for EE (Express Enrollment) in BadgerCare Plus or Family Planning Only Services but the member's enrollment is not on file yet in the EVS, the provider should check enrollment again in two days or wait one week to submit a claim to ForwardHealth. If, after two days, the EVS indicates that the member still is not enrolled or the claim is denied with an enrollment-related EOB (Explanation of Benefits) code, the provider should contact Provider Services for assistance.

When a member who received a real-time eligibility determination presents a temporary ID card but the member's enrollment is not on file yet in the EVS, the provider should wait up to one week to submit a claim to ForwardHealth. If the claim is denied with an enrollment-related EOB code, the provider should contact Provider Services for assistance.

Overpayments

Topic #528

Adjustment Request vs. Cash Refund

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

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

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 Wis. Admin. Code DHS 106.08.
- 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

Wisconsin Medicaid 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 (08/15)) 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, Wisconsin Medicaid will deduct the overpayment from future reimbursement amounts.

Topic #533

Cash Refunds

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

ForwardHealth
Financial Services Cash Unit
313 Blettner Blvd
Madison WI 53784

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 #530

Requirements

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

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

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

- Return of overpayment through the adjustment request process
- Return of overpayment with a cash refund
- Return of overpayment with a voided claim
- 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

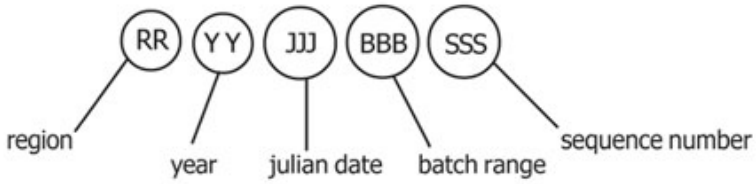
control number)). However, denied real-time compound and noncompound claims are not assigned an ICN, but receive an authorization number. Authorization numbers are not reported to the RA (Remittance Advice) or 835 (835 Health Care Claim Payment/Advice).

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 #644

ClaimCheck Review

ForwardHealth monitors all professional claims for compliance with reimbursement policy using an automated procedure coding review software known as McKesson ClaimCheck. ClaimCheck reviews claims submitted for billing inconsistencies and errors during claims processing. Insurance companies, Medicare, and other state Medicaid programs use similar software.

EOB (Explanation of Benefits) codes specific to the ClaimCheck review appear in the TXT (text) RA (Remittance Advice) file and in the electronic 835 (835 Health Care Claim Payment/Advice) transactions.

ClaimCheck review does not change Medicaid or BadgerCare Plus policy on covered services but monitors compliance with policy more closely and reimburses providers appropriately.

Areas Monitored by ClaimCheck

ForwardHealth uses ClaimCheck software to monitor the following situations:

- Unbundled procedures
- Incidental/integral procedures
- Mutually exclusive procedures
- Medical visit billing errors
- Preoperative and postoperative billing errors
- Medically obsolete procedures
- Assistant surgeon billing errors
- Gender-related billing errors

ClaimCheck will not review claims that have been denied for general billing errors, such as an invalid member identification number or an invalid or missing provider number. Providers will need to correct the general billing error and resubmit the claim, at which point ClaimCheck will review the claim.

Unbundled Procedures

Unbundling occurs when two or more procedure codes are used to describe a procedure that may be better described by a single, more comprehensive procedure code. ClaimCheck considers the single, most appropriate procedure code for reimbursement when unbundling is detected.

If certain procedure codes are submitted, ClaimCheck rebundles them into the single most appropriate procedure code. For example, if a provider submits a claim with procedure codes 12035 (Repair, intermediate, wounds of scalp, axillae, trunk and/or

extremities [excluding hands and feet]; 12.6 cm to 20.0 cm) and 12036 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities [excluding hands and feet]; 20.1 cm to 30.0 cm), ClaimCheck rebundles them to procedure code 12037 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities [excluding hands and feet]; over 30.0 cm).

ClaimCheck will also total billed amounts for individual procedures. For example, if the provider bills three procedures at $20, $30, and $25, ClaimCheck rebundles them into a single procedure code, adds the three amounts, and calculates the billed amount for that rebundled code at $75. Then, ForwardHealth reimburses the provider either the lesser of the billed amounts or the maximum allowable fee for that rebundled procedure code.

Incidental/Integral Procedures

Incidental procedures are those procedures performed at the same time as a more complex primary procedure. These require few additional provider resources and are generally not considered necessary to the performance of the primary procedure. For example, the removal of an asymptomatic appendix is considered an incidental procedure when done during hysterectomy surgery.

Integral procedures are those procedures performed as part of a more complex primary procedure. For example, when a member undergoes a transurethral incision of the prostate, the cystourethroscopy (procedure code 52000) is considered integral to the performance of the prostate procedure and would be denied.

When a procedure is either incidental or integral to a major procedure, ClaimCheck considers only the primary procedure for reimbursement.

Mutually Exclusive Procedures

Mutually exclusive procedures are procedures that would not be performed on a single member on the same day or that use different codes to describe the same type of procedure.

For example, procedure code 58260 (Vaginal hysterectomy, for uterus 250 g or less) and procedure code 58150 (Total abdominal hysterectomy [corpus and cervix], with or without removal of tube[s], with or without removal of ovary[s]) are mutually exclusive — either one or the other, procedure is performed, but not both.

When two or more procedures are mutually exclusive, ForwardHealth considers for reimbursement the procedure code with the highest provider-billed amount and denies the other code.

Medical Visit Billing Errors

Medical visit billing errors occur if E&M (evaluation and management) services are reported separately when a substantial diagnostic or therapeutic procedure is performed. Under CMS (Centers for Medicare and Medicaid Services) guidelines, most E&M procedures are not allowed to be reported separately when a substantial diagnostic or therapeutic procedure is performed.

Medical visit edits monitor services included in CPT (Current Procedural Terminology) procedure ranges 92002-92019, 99024 (postoperative follow-up), 99026-99058 (special services), 99201-99456 (E&M codes) and HCPCS (Healthcare Common Procedure Coding System) codes S0620, S0621 (routine ophthalmological examinations).

ClaimCheck monitors medical visits based on the type of E&M service (i.e., initial or new patient; or follow-up or established patient services) and the complexity (i.e., major or minor) of the accompanying procedure.

For example, if a provider submits procedures 22630 (Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace [other than for decompression], single interspace; lumbar) and 99221 (Initial hospital care, per day), ClaimCheck denies procedure 99221 as a visit when submitted with procedure 22630 with the same DOS (date of service). Procedure code 22630 is a major procedure with a 90-day global surgical period.

Preoperative and Postoperative Billing Errors

Preoperative and postoperative billing errors occur when E&M services are billed with surgical procedures during their preoperative and postoperative periods. ClaimCheck bases the preoperative and postoperative periods on designations in the CMS National Physician Fee Schedule.

For example, if a provider submits procedure code 99212 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making [10 minutes]) with a DOS of 11/02/08 and procedure 27750 (Closed treatment of tibial shaft fracture [with or without fibular fracture]; without manipulation) with a DOS of 11/03/08, ClaimCheck will deny procedure code 99212 as a preoperative visit because it is submitted with a DOS one day prior to the DOS for procedure code 27750.

Medically Obsolete Procedures

Obsolete procedures are procedures that are no longer performed under prevailing medical standards. Claims for procedures designated as obsolete are denied.

Assistant Surgeon Billing Errors

ClaimCheck development and maintenance of assistant surgeon values includes two designations, *always* and *never*. ClaimCheck uses the ACS (American College of Surgeons) as its primary source for determining assistant surgeon designations. ForwardHealth's list of procedure codes allowable with an assistant surgeon designation is consistent with ClaimCheck.

For example, if a provider bills procedure code 10040 (Acne surgery [eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules]) with modifier 80 (assistant surgeon), ClaimCheck determines that the procedure does not require an assistant surgeon and denies the procedure code.

Gender-Related Billing Errors

Gender-related billing errors occur when a provider submits a gender-specific procedure for a patient of the opposite sex. ForwardHealth has adopted ClaimCheck's designation of gender for procedure codes.

For example, if a provider submits procedure code 58150 (Total abdominal hysterectomy [corpus and cervix], with or without removal of tube[s], with or without removal of ovary[s]) for a male, ClaimCheck will deny the procedure based on the fact that procedure code 58150 is a female gender-specific procedure.

Payments Denied as a Result of the ClaimCheck Review

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

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

If a provider disagrees with ClaimCheck's determination, the provider may resubmit the claim with supporting documentation to Provider Service Written Correspondence. If the original claim is in an allowed status, the provider may submit an Adjustment/Reconsideration Request (F-13046 (08/15)) with supporting documentation and the words "medical consultant

review requested" written on the form to Provider Services Written Correspondence.

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 121 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 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

ForwardHealth offers electronic billing software at no cost to providers. The PES (Provider Electronic Solutions) software allows providers to submit electronic claims and claim reversals, and 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 #11537

National Correct Coding Initiative

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

reimbursement.

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

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

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

Medically Unlikely Detail Edits

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

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

Procedure-to-Procedure Detail Edits

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

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

Quarterly Code List Updates

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

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

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

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

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

- Complete the Adjustment/Reconsideration Request (F-13046 (08/15)) form. In Element 16, select the "Consultant review requested" checkbox and the "Other/comments" checkbox. In the "Other/comments" text box, indicate "Reconsideration of an NCCI denial."
- Attach notes/supporting documentation.
- Submit a claim, Adjustment/Reconsideration Request, and additional notes/supporting documentation to ForwardHealth for processing.

Topic #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 121 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) include 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
- Noncompound 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	Provider Types
Dental claims	Dentists, dental hygienists, HealthCheck agencies that provide dental services
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
Noncompound and compound drug claims	Pharmacies and dispensing physicians
Outpatient claims	Outpatient hosptial 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, physicial 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 #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 type of financial transaction that created the accounts receivable.	V — Capitation adjustment 1 — OBRA Level 1 screening void request 2 — OBRA Nurse Aide Training/Testing void request
Identifier — 10 additional numbers are assigned to complete the Adjustment ICN.	The identifier is used internally by ForwardHealth.

Service Code Descriptions

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

Summary

The Summary section reviews the provider's claim activity and financial transactions with the payer (Medicaid, ADAP (Wisconsin AIDS Drug Assistance Program), 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

```
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

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

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

MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    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 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

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                  PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          CHECK/EFT NUMBER    999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, 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: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MEMBER NO.: XXXXXXXXXXX
RRYYJJJBBBSSS  XXXXXXXXXXX  XXXXXXXXXXX  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, ADAP (Wisconsin AIDS Drug Assistance Program), 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)
- ADAP (Wisconsin AIDS Drug Assistance Program)
- WCDP (Wisconsin Chronic Disease Program)
- WWWP (Wisconsin Well Woman Program)

A separate Portal account is required for each financial payer.

Note: Each of the four 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
- Noncompound 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, ADAP (Wisconsin AIDS Drug Assistance Program), 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 #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).

Exceptions to the Submission Deadline

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

- Change in a nursing home resident's LOC (level of care) or liability amount

- Decision made by a court order, fair hearing, or the Wisconsin 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 #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, plus a professional dispensing fee, if applicable, or the maximum allowable fee established.

Submission

Topic #17797

1500 Health Insurance Claim Form Completion Instructions

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

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

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

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

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

Submit completed paper claims and the completed Explanation of Medical Benefits form, as applicable, to the following address:

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

Item Number 6 — Patient Relationship to Insured
Enter "X" in the "Self" box to indicate the member's relationship to insured when Item Number 4 is completed. Only one box can be marked.

Item Number 9 — Other Insured's Name (not required)
This field is not required on the claim.

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

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

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

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

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

Item Number 10d — Claim Codes (Designated by NUCC)
When applicable, enter the Condition Code. The Condition Codes approved for use on the 1500 Health Insurance Claim Form are available on the NUCC website under Code Sets.

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

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

Item Number 11d — Is There Another Health Benefit Plan?
This field is not used for processing by ForwardHealth.

Item Number 19 — Additional Claim Information (Designated by NUCC)
When applicable, enter provider identifiers or taxonomy codes. A list of applicable qualifiers are defined by the NUCC and can be found in the NUCC 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12, prepared by the NUCC.

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

Item Number 22 — Resubmission Code and/or Original Reference Number
This field is not used for processing by ForwardHealth.

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

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

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

For additional information about submitting a 1500 Health Insurance Claim Form with supplemental NDC information, refer to the completion instructions located under "Section 24" in the Field Specific Instructions section of the NUCC's 1500 Health Insurance

Claim Form Reference Instruction Manual for Form Version 02/12.

Item Number 24C — EMG
Enter a "Y" in the unshaded area for each procedure performed as an emergency. If the procedure was not an emergency, leave this field blank.

Item Number 29 — Amount Paid (not required)
This field is not required on the claim.

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

Topic #10677

Advanced Imaging Services

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

Submitting Claims for Situations Exempt From the Prior Authorization Requirement

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

- The service is provided during a member's inpatient hospital stay.
- The service is provided when a member is in observation status at a hospital.
- The service is provided as part of an emergency room visit.
- The service is provided as an emergency service.
- The ordering provider is exempt from the PA requirement.

Service Provided During an Inpatient Stay

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

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

Service Provided for Observation Status

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

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

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

Service Provided as Part of Emergency Room Visit

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

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

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

Service Provided as Emergency Service

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

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

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

Ordering Provider Is Exempt from Prior Authorization Requirement

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

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

Topic #542

Attached Documentation

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

Topic #20082

Claims for Drugs Purchased Through the 340B Drug Pricing Program

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

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

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

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

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

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

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

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

claim with a submission clarification code of "2" will be reimbursed at the lesser of the calculated 340B ceiling price or the provider-submitted 340B AAC plus a professional dispensing fee. If a calculated 340B ceiling price is not available for a drug, ForwardHealth will reimburse 340B ingredient cost at the lesser of WAC minus 50 percent or the provider-submitted 340B AAC plus a professional dispensing fee.

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

Basis of Cost Determination and Submission Clarification Code

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

Professional Claim Modifier for Drugs Purchased Through the 340B Program

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

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

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

Topic #6957

Copy Claims on the ForwardHealth Portal

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

Topic #5017

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

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

Topic #4997

Direct Data Entry of Professional and Institutional Claims on the Portal

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

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

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

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

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

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

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

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

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

- Procedure codes

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

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

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

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

Topic #15957

Documenting and Billing the Appropriate National Drug Code

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

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

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

Topic #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 #1271

Electronic claims for nurse midwife services must be submitted using the 837P (837 Health Care Claim: Professional) transaction. Claims for nurse midwife services submitted using any transaction other than the 837P will be denied.

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

Provider Electronic Solutions Software

The DMS (Division of Medicaid Services) 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 #16937

Electronic Claims and Claim Adjustments With Other Commercial Health Insurance Information

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

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

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

Adjustments to Claims Submitted Prior to June 16, 2014

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

Topic #365

Extraordinary Claims

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

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 #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 #10837

Note Field for Most Claims Submitted Electronically

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

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

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

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

- Professional
- Institutional
- Dental

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

Claims Submitted via 837 Health Care Claim Transactions

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

Topic #561

Paper Claim Form Preparation and Data Alignment Requirements

Optical Character Recognition

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

The data alignment requirements do not apply to the Compound Drug Claim (F-13073 (04/17)) and the Noncompound Drug Claim (F-13072 (04/17)).

Speed and Accuracy of Claims Processing

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

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

Handwritten Claims

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

Use Original Claim Forms

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

Use Laser or Ink Jet Printers

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

Alignment

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

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

The following sample claim forms demonstrate correct and incorrect alignment:

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

Clarity

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

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

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

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

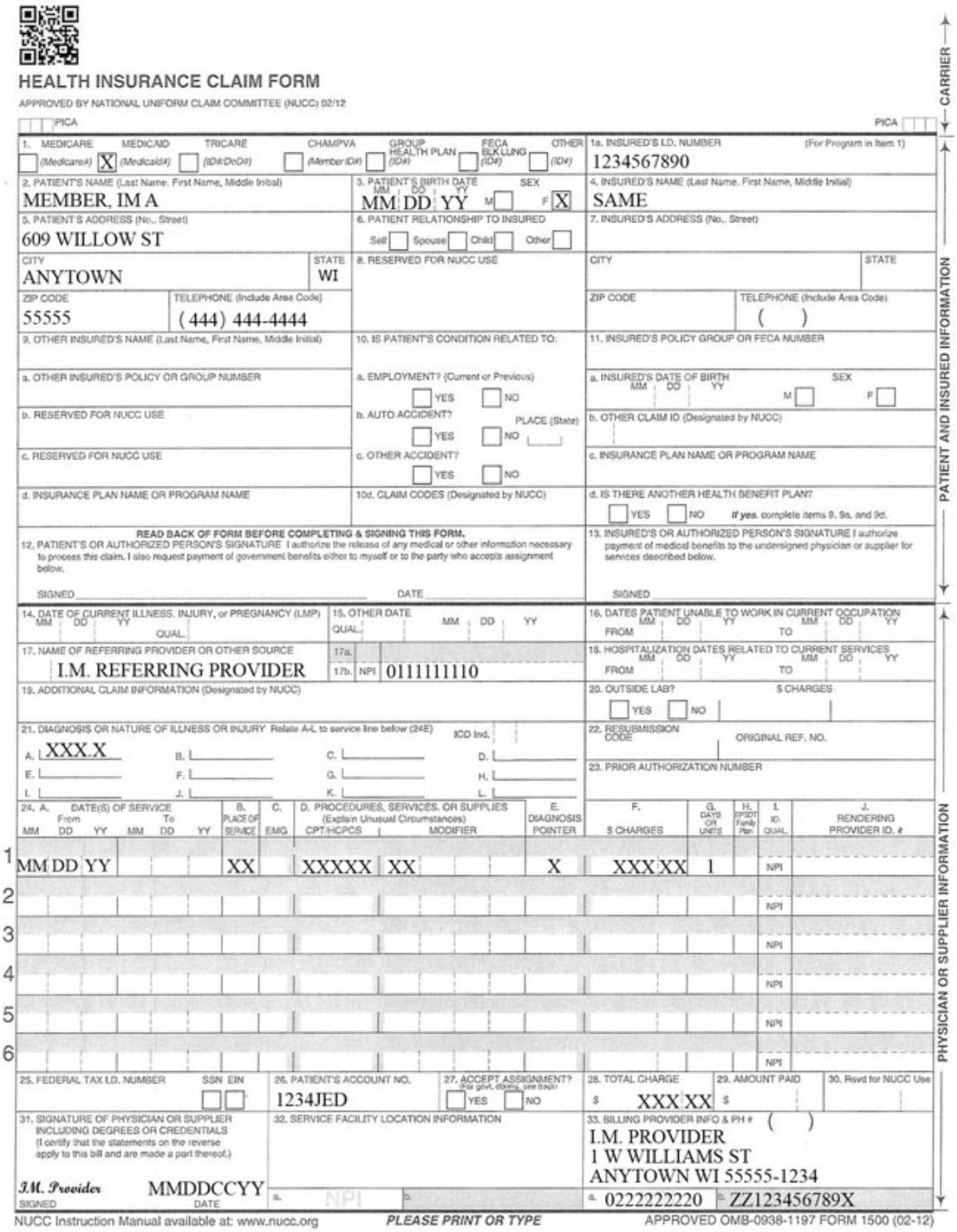
Staples, Correction Liquid, and Correction Tape

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

Additional Diagnosis Codes

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

Sample of a Correctly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

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

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

CITY: ANYTOWN | STATE: WI

8. RESERVED FOR NUCC USE

CITY | STATE

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

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

15. OTHER DATE QUAL. MM DD YY

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

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

17a.

17b. NPI 0111111110

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

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

A. XXX.X B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

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

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

I.M. Provider MMDDCCYY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

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

a. 0222222220 b. ZZ123456789X

PATIENT AND INSURED INFORMATION

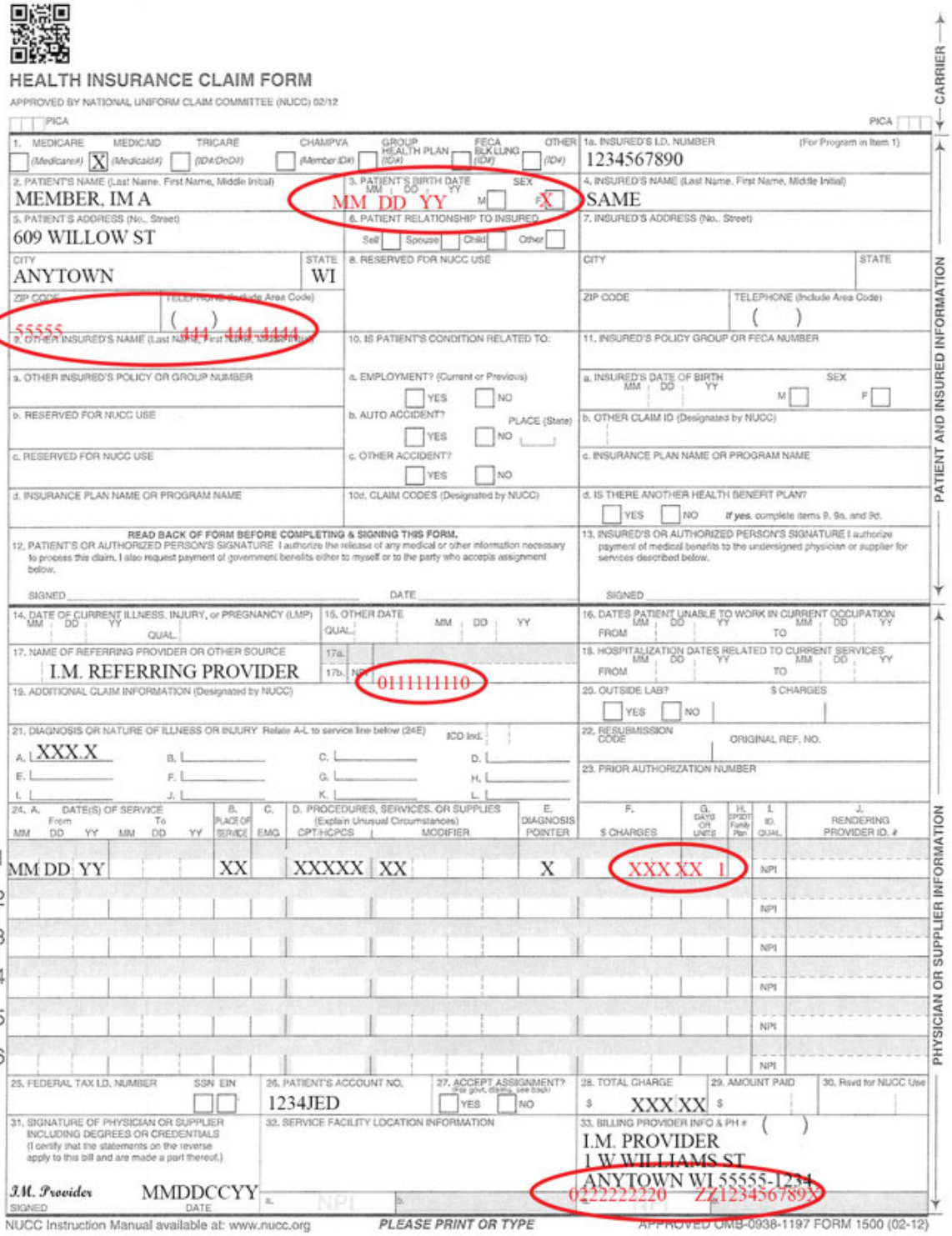
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Sample of an Incorrectly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

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

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

CITY: ANYTOWN | STATE: WI

8. RESERVED FOR NUCC USE

CITY | STATE

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

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL MM DD YY

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

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

17a.

17b. NPI: 0111111110

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. XXX.X B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

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

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

I.M. Provider MMDDCCYY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

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

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

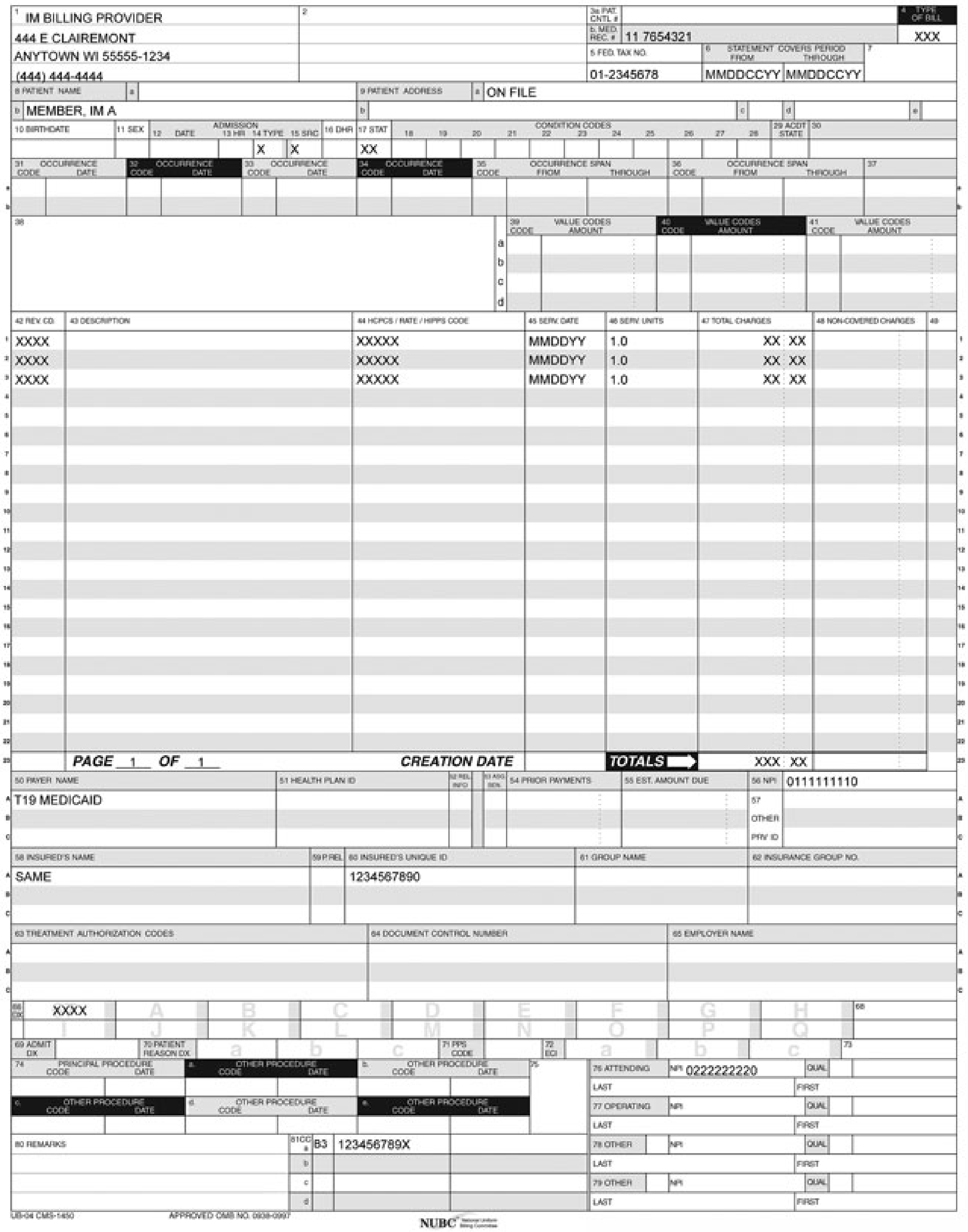
APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample of a Correctly Aligned UB-04 Claim Form



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

2

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

4 TYPE OF BILL: XXX

5 FED. TAX NO.: 01-2345678

6 STATEMENT COVERS PERIOD FROM: MMDDCCYY THROUGH: MMDDCCYY

7

8 PATIENT NAME a
b MEMBER, IM A

9 PATIENT ADDRESS a ON FILE
b c d e

10 BIRTHDATE | 11 SEX | ADMISSION 12 DATE | 13 HR | 14 TYPE: X | 15 SRC: X | 16 DHR | 17 STAT: XX | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 CODE OCCURRENCE SPAN FROM THROUGH | 36 CODE OCCURRENCE SPAN FROM THROUGH | 37

38

39 CODE VALUE CODES AMOUNT | 40 CODE VALUE CODES AMOUNT | 41 CODE VALUE CODES AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
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 | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI: 0111111110 | 57 OTHER PRV ID

58 INSURED'S NAME: A SAME | 59 P. REL | 60 INSURED'S UNIQUE ID: 1234567890 | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX: XXXX | 67 A B C D E F G H I J K L M N O P Q | 68

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

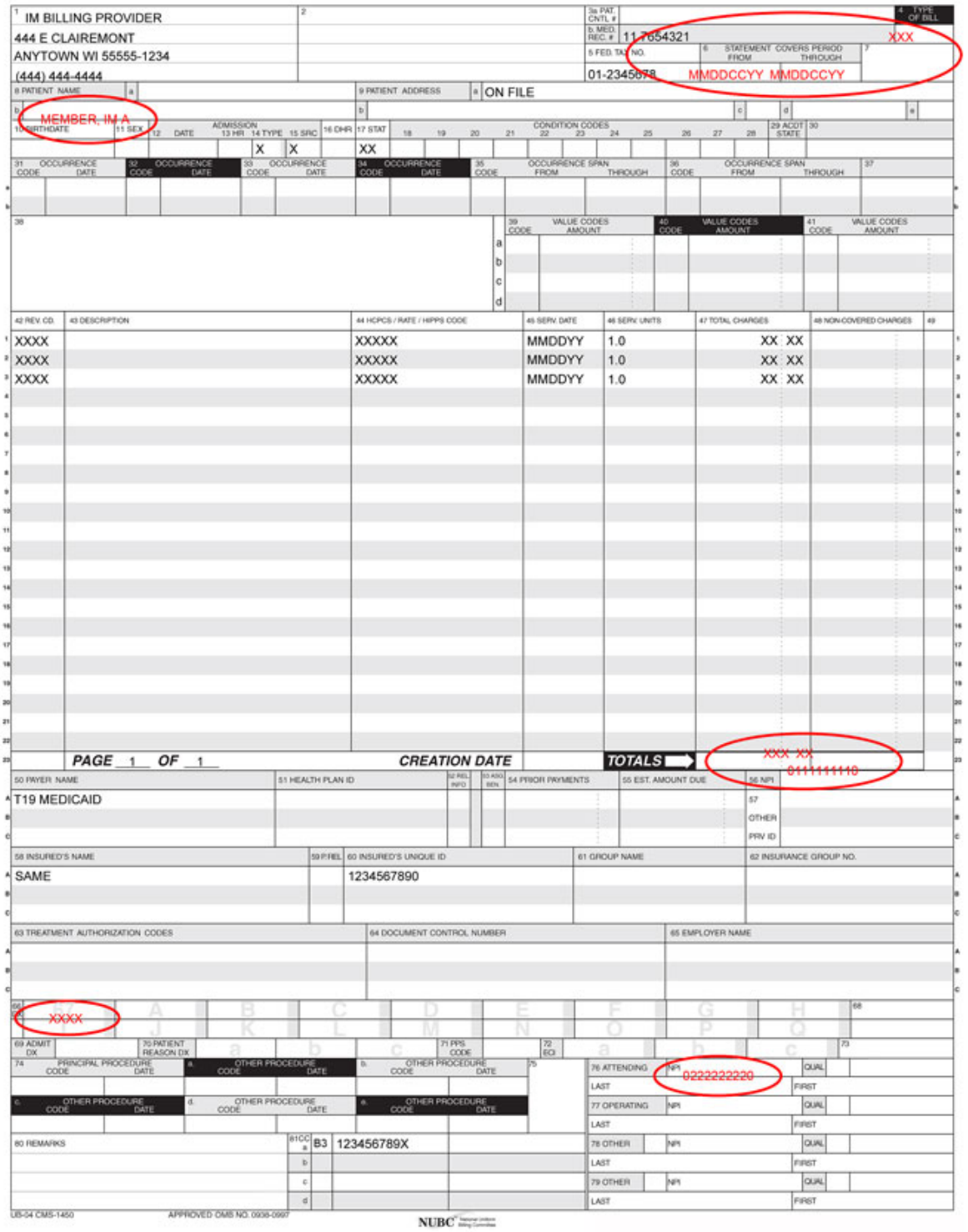
76 ATTENDING NPI 0222222220 QUAL
LAST FIRST
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS

81CC a B3 123456789X
b
c
d

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

Sample of an Incorrectly Aligned UB-04 Claim Form



Topic #1272

Paper Claim Submission

Paper claims for nurse midwife services must be submitted using the 1500 Health Insurance Claim Form ((02/12)). Paper claims for nurse midwife services submitted on any other claim form will be denied.

Providers should use the appropriate claim form instructions for nurse midwife services when submitting these claims.

Obtaining the Claim Forms

ForwardHealth does not provide the 1500 Health Insurance Claim Form. The form may be obtained from any federal forms supplier.

Topic #4382

Provider-Administered Drugs

Deficit Reduction Act of 2005

Providers are required to comply with requirements of the federal DRA (Deficit Reduction Act) of 2005 and submit NDCs (National Drug Codes) with HCPCS (Healthcare Common Procedure Coding System) procedure codes on claims for provider-administered drugs. Section 1927(a)(7)(C) of the Social Security Act requires NDCs to be indicated on all claims submitted to ForwardHealth for covered outpatient drugs, including Medicare crossover claims.

ForwardHealth requires that NDCs be indicated on claims for all provider-administered drugs to identify the drugs and invoice a manufacturer for rebates, track utilization, and receive federal funds. States that do not collect NDCs with HCPCS procedure codes on claims for provider-administered drugs will not receive federal funds for those claims. ForwardHealth cannot claim a rebate or federal funds if the NDC submitted on a claim is incorrect or invalid or if an NDC is not indicated.

If an NDC is not indicated on a claim submitted to ForwardHealth, or if the NDC indicated is invalid, the claim will be denied.

Note: Vaccines are exempt from the DRA requirements. Providers who receive reimbursement under a bundled rate are not subject to the DRA requirements.

Less-Than-Effective Drugs

ForwardHealth will deny provider-administered drug claims for ForwardHealth members for LTE (less-than-effective) drugs as identified by the federal CMS (Centers for Medicare and Medicaid Services) or identical, related, or similar drugs.

Claim Submission

Institutional Claims

Providers that submit claims for services on an institutional claim also are required to submit claims for provider-administered drugs on an institutional claim.

Institutional claims that include provider-administered drugs must be submitted to ForwardHealth fee-for-service for fee-for-service members and to the HMO for managed care members.

Professional Claims

Providers that submit claims for services on a professional claim also are required to submit claims for provider-administered drugs on a professional claim.

Professional claims that include provider-administered drugs must be submitted to ForwardHealth fee-for-service for fee-for-service members.

Professional claims for provider-administered drugs must be submitted to ForwardHealth fee-for-service for managed care members. Other services submitted on a professional claim must be submitted to the HMO for managed care members.

The following POS (place of service) codes will not be accepted by Medicaid fee-for-service when submitted by a provider on a professional claim:

POS Code	Description
06	Indian Health Services Provider-Based Facility
08	Tribal 638 Provider-Based Facility
21	Inpatient Hospital
22	On Campus — Outpatient Hospital
23	Emergency Room — Hospital
51	Inpatient Psychiatric Facility
61	Comprehensive Inpatient Rehabilitation Facility
65	ESRD Treatment Facility

Medicare Crossover Claims

To be considered for reimbursement, NDCs and a HCPCS procedure code must be indicated on Medicare crossover claims.

ForwardHealth will deny crossover claims if an NDC was not submitted to Medicare with a provider-administered drug HCPCS code.

340B Providers

The 340B Program (340B Drug Pricing Program) enables covered entities to fully utilize federal resources, reaching more eligible patients and providing more comprehensive services. Providers who participate in the 340B Program are required to indicate an NDC on claims for provider-administered drugs. When submitting the 340B billed amount, they are also required to indicate the AAC (Actual Acquisition Cost) and appropriate claim level identifier(s).

Explanation of Benefits Codes on Claims for Provider-Administered Drugs

Providers will receive an EOB (Explanation of Benefits) code on claims with a denied detail for a provider-administered drug if the claim does not comply with the standards of the DRA. If a provider receives an EOB code on a claim for a provider-administered drug, he or she should correct and resubmit the claim for reimbursement.

Provider-Administered Claim Denials

If a clinic's professional claim with a HCPCS code is received by ForwardHealth and a subsequent claim for the same drug is received from a pharmacy, having a DOS (date of service) within seven days of the clinic's DOS, then the pharmacy's claim will be denied as a duplicate claim.

Reconsideration of the denied drug claim may occur if the claim was denied with an EOB code and the drug therapy was due to the treatment for an acute condition. To submit a claim that was originally denied as a duplicate, pharmacies should complete and submit the Noncompound Drug Claim (F-13072 (04/17)) form along with the Pharmacy Special Handling Request (F-13074 (07/12)) form indicating the EOB code and requesting an override.

Provider-Administered Drugs Carve-Out Code Sets

Provider-administered drugs carve-out policy is defined to include the following procedure codes:

- Drug-related "J" codes
- Drug-related "Q" codes
- Certain drug-related "S" codes

The Provider-Administered Drugs Carve-Out Procedure Codes table indicates the status of procedure codes considered under the provider-administered drugs carve-out policy. This table provides information on Medicaid and BadgerCare Plus coverage status as well as carve-out status based on POS.

Note: The table will be revised in accordance with national annual and quarterly HCPCS code updates.

Provider-administered drugs carve-out policy applies to certain procedure code sets, services, POS, and claim types. A service is carved-out based on the procedure code, POS, and claim type on which the service is submitted. It is important to note that provider-administered drugs may be given in many different practice settings and submitted on different claim types. Whether the service is carved in or out depends on the combination of these factors, not simply on the procedure code.

Claims for dual eligibles should be submitted to Medicare first before they are submitted to ForwardHealth. Providers should continue to submit claims for other services to the member's MCO.

Provider-administered drugs and related services for members enrolled in PACE (Program for All-Inclusive Care for the Elderly) are provided and reimbursed by the special managed care program.

Note: For Family Care Partnership members who are not enrolled in Medicare (Medicaid-only members), outpatient drugs (excluding diabetic supplies), provider-administered drugs, compound drugs (including parenteral nutrition), and any other drugs requiring drug utilization review are covered by fee-for-service Medicaid. All fee-for-service policies, procedures, and requirements apply for pharmacy services provided to Medicaid-only Family Care Partnership members. Dual eligibles (enrolled in Medicare and Medicaid) receive their outpatient drugs through their Medicare Part D plans. However, if the member's Part D plan does not cover the outpatient drug, these dually eligible members may access certain Medicaid outpatient drugs that are excluded or otherwise restricted from Medicare coverage through fee-for-service Medicaid. For these drugs, fee-for-service policies would apply.

Exemptions

Claims for drugs included in the cost of the procedure (e.g., a claim for a dental visit where lidocaine is administered) should be submitted to the member's MCO.

Vaccines and their administration fees are reimbursed by a member's MCO.

Providers who receive reimbursement under a bundled rate are reimbursed by a member's MCO.

Providers who were reimbursed a bundled rate by the member's MCO for certain services (e.g., hydration, catheter maintenance, TPN (total parenteral nutrition)) should continue to be reimbursed by the member's MCO. Providers should work with the member's MCO in these situations.

Additional Information

Additional information about the DRA and claim submission requirements can be located on the following Web sites:

- CMS (Centers for Medicare and Medicaid Services) DRA information page
- NUBC (National Uniform Billing Committee)
- NUCC (National Uniform Claim Committee)

For information about NDCs, providers may refer to the following Web sites:

- The FDA (Food and Drug Administration) website
- The Drug Search Tool (Providers may verify if an NDC and its segments are valid using this website.)

Topic #10237

Claims for Provider-Administered Drugs

Claims for provider-administered drugs may be submitted to ForwardHealth via the following:

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

1500 Health Insurance Claim Form

These instructions apply to claims submitted for provider-administered drugs. NDCs for provider-administered drugs must be indicated in the shaded area of Item Numbers 24A-24G on the 1500 Health Insurance Claim Form. The NDC must be accompanied by an NDC qualifier, unit qualifier, and units. To indicate an NDC, providers should do the following:

- Indicate the NDC qualifier "N4," followed by the 11-digit NDC of the drug dispensed, with no space in between.
- Indicate one space between the NDC and the unit qualifier.
- Indicate one unit qualifier (F2 [International unit], GR [Gram], ME [Milligram], ML [Milliliter], or UN [Unit]), followed by the NDC units, with no space in between (For further instruction on submitting a 1500 Health Insurance Claim Form with supplemental NDC information, providers may refer to the 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12 on the NUCC (National Uniform Claim Committee) website.)

Providers should indicate the appropriate NDC of the drug that was dispensed that corresponds to the HCPCS procedure code on claims for provider-administered drugs. If an NDC is not indicated on the claim, or if the NDC indicated is invalid, the claim will be denied.

837 Health Care Claim: Professional Transactions

Providers may refer to the NUCC Web site for information about indicating NDCs on provider-administered drug claims submitted using the 837P transaction.

Direct Data Entry on the ForwardHealth Portal

The following must be indicated on provider-administered drug claims submitted using DDE on the Portal:

- The NDC of the drug dispensed
- Quantity unit

- Unit of measure

Note: The "N4" NDC qualifier is not required on claims submitted on the Portal.

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. The PES software allows providers to submit 837P transactions, adjust claims, and check claim status. 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 #10637

Reimbursement Reduction for Most Paper Claims

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

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

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

The reimbursement reduction applies to the following paper claims:

- 1500 Health Insurance Claim Form ((02/12))
- UB-04 (CMS 1450) Claim Form
- Compound Drug Claim (F-13073 (04/17)) form
- Noncompound Drug Claim (F-13072 (04/17)) form

Exceptions to Paper Claim Reimbursement Reduction

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

- In-state emergency providers
- Out-of-state providers
- Medicare crossover claims
- Any claims that ForwardHealth requires additional supporting information to be submitted on paper, such as:
  - Hysterectomy claims must be submitted along with an Acknowledgment of Receipt of Hysterectomy Information (F-01160 (06/13)) form
  - Sterilization claims must be submitted along with a paper Consent for Sterilization (F-01164 (10/08)) form.
  - Claims submitted to Timely Filing appeals must be submitted on paper with a Timely Filing Appeals Request (F-13047 (08/15)) form.
  - In certain circumstances, drug claims must be submitted on paper with a Pharmacy Special Handling Request (F-13074 (07/12)) form.
  - Claims submitted with four or more NDCs (National Drug Codes) for compound and noncompound drugs with specific and non-specific HCPCS (Healthcare Common Procedure Coding System) procedure codes.

Topic #18197

Sleep Medicine Testing

Facility-Based Sleep Studies and Polysomnography

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

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

Home-Based Sleep Studies

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

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

Topic #1251

Submitting Claims or Claim Adjustments for Separate Obstetric Care Components

When a provider does not meet the requirements to use global obstetric procedure codes on claims or claim adjustments for obstetric services, the provider is required to submit claims or claim adjustments for obstetric services as separate obstetric care components.

Claims or Claim Adjustments for Antepartum Care Visits

Antepartum care includes the following:

- Dipstick urinalysis.
- Routine exams.
- Recording of weight, blood pressure, and fetal heart tones.

Per ACOG (American Congress of Obstetricians and Gynecologists) guidelines, providers are required to complete **all** antepartum care visits before submitting claims or claim adjustments to ForwardHealth.

When submitting claims or claim adjustments for antepartum care as separate obstetric care components, the provider is required to use the following guidelines based on the number of antepartum care visits rendered:

- If the provider renders **three or fewer** antepartum care visits, the provider is required to submit a separate claim/claim detail (or adjustment) for **each** visit as follows:

- Use the appropriate **E&M (evaluation and management) service code** representing the POS (place of service) and visit level.
- Include modifier TH (Obstetrical treatment/services, prenatal or postpartum) with the E&M service code.
- Indicate the quantity as "1.0."
- Indicate the date of the visit as the DOS (date of service).

- If the provider renders **four to six** antepartum care visits, the provider is required to submit one claim/claim detail (or adjustment) covering **all** visits as follows:
  - Use the **antepartum care code** 59425 (Antepartum care only; 4-6 visits).
  - Indicate the quantity as "1.0."
  - Indicate the date of the last antepartum care visit as the DOS.
- If the provider renders **seven or more** antepartum care visits, the provider is required to submit one claim/claim detail (or adjustment) covering **all** visits as follows:
  - Use the **antepartum care code** 59426 (Antepartum care only; 7 or more visits).
  - Indicate the quantity as "1.0."
  - Indicate the date of the last antepartum care visit as the DOS.

Note: A telephone call between the member and provider does not qualify as an antepartum care visit.

The table below summarizes these guidelines.

Total Antepartum Care Visits	Procedure Code to Submit	Allowable Modifier(s)	Quantity to Indicate	Date of Service to Indicate
1-3 (submit separate claim/claim detail for **each** visit)	Appropriate E&M service code representing POS and level of care	TH (Obstetrical treatment/services, prenatal or postpartum) TJ (Program group, child and/or adolescent) AQ (Physician providing a service in a HPSA (Health Professional Shortage Area))	1.0	Date of visit
4-6 (submit one claim/claim detail covering **all** visits)	59425 (Antepartum care only; 4-6 visits)	AQ	1.0	Date of last antepartum care visit
7+ (submit one claim/claim detail covering **all** visits)	59426 (Antepartum care only; 7 or more visits)	AQ	1.0	Date of last antepartum care visit

Reimbursement for antepartum care is limited to once per pregnancy, per member, per billing provider.

Claims or Claim Adjustments for Delivery

Delivery includes the following:

- Patient preparation.
- Placement of fetal heart or uterine monitors.
- Insertion of catheters.
- Delivery of the child and placenta.
- Injections of local anesthesia.
- Induction of labor.
- Artificial rupture of membranes.

Multiple Deliveries

When there are multiple deliveries (e.g., twins or triplets), one claim or claim adjustment must be submitted for all of the deliveries as follows:

- On the first detail line of the claim or claim adjustment, the provider is required to indicate the appropriate global obstetric procedure code or delivery-only procedure code for the first delivery.
- The provider is required to indicate additional births on separate detail lines of the claim or claim adjustment, using the appropriate delivery-only procedure code for each subsequent delivery.

Claims or Claim Adjustments for Postpartum Care

Postpartum care includes all routine management and care of the postpartum patient provided during the postpartum inpatient hospital visit and the postpartum outpatient/office visit.

In accordance with ACOG standards, Wisconsin Medicaid reimburses for postpartum care (or global obstetric care), provided that **both** routine postpartum inpatient hospital care **and** a postpartum outpatient/office visit occur. Postpartum inpatient hospital care alone is included in the reimbursement for delivery.

When submitting a claim or claim adjustment for postpartum care, the DOS is the date of the postpartum outpatient/office visit. In order to receive reimbursement, the postpartum visit must be performed outside of the inpatient hospital setting.

The length of time between a delivery and the postpartum outpatient/office visit should be dictated by good medical practice. ForwardHealth does not dictate an "appropriate" period for postpartum care; however, the industry standard is six to eight weeks following delivery. A telephone call between the member and provider does **not** qualify as a postpartum visit.

Claims or Claim Adjustments for Delivery and Postpartum Care

Providers who perform both the delivery and postpartum care may submit claims or claim adjustments with either the separate delivery and postpartum codes or the delivery including postpartum care CPT procedure code, as appropriate. The DOS to indicate for the combination codes is the delivery date. However, if the member does not return for the postpartum visit, the provider is required to adjust the claim to reflect delivery only, or the reimbursement will be recouped through an audit.

Topic #15977

Submitting Multiple National Drug Codes per Procedure Code

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

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

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

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

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

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

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

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

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

Procedure Code	NDC	NDC Description
J3490	00406-3245-57	Hydromorphone HCl Powder — 1 mg
J3490	38779-0524-03	Bupivacaine HCl Powder — 125 mg
J3490	00409-7984-13	Sodium Chloride 0.9% Solution — 50 ml

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

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	N400406324557 ME1															
	11	13	14	11	13	14	11		J3490	KP	AC	500 00	1	N	NPI	0123456789
2	N438779052403 ME125															
	11	13	14	11	13	14	11		J3490	KQ	AC	500 00	1	N	NPI	0123456789
3	N400409798413 ML50															
	11	13	14	11	13	14	11		J3490		AC	500 00	1	N	NPI	0123456789

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

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

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

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

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

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 #15317

Surgical Procedures Billed on Professional Claims

Certain surgical procedures billed on professional claims (i.e., the 837P (837 Health Care Claim: Professional) transaction or the 1500 Health Insurance Claim Form ((02/12))) may be reimbursed only when performed in an inpatient hospital or an ASC (ambulatory surgery center).

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 mail ForwardHealth a Timely Filing Appeals Request form (F-13047 (08/15)) with a paper claim or an Adjustment/Reconsideration Request form (F-13046 (08/15)) to override the submission deadline. If claims or adjustment requests are submitted electronically, the entire amount of the claim will be recouped.

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 (08/15)) 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 (08/15)) form for each claim and each adjustment to allow for documentation of individual claims and adjustments submitted to ForwardHealth
- A legible claim or Adjustment/Reconsideration Request (F-13046 (08/15)) form
- All required documentation as specified for the exception to the submission deadline
- A properly completed Explanation of Medical Benefits form for paper claims and paper claim adjustments where other health insurance sources are indicated

Note: Providers are reminded to complete and submit the most current versions of these forms supported by ForwardHealth.

To receive consideration for an exception, a Timely Filing Appeals Request form must be received by ForwardHealth before the applicable submission deadlines specified for the exception.

When completing the claim or adjustment request, providers are required to indicate the procedure code, diagnosis code, POS (place of service) code, and all other required claims data elements 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 additional 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 LOC (level of care) or liability amount.	To receive consideration, the request must be submitted within 455 days from the DOS. Include the following documentation as part of the request: - The correct liability amount or LOC must be indicated on the Adjustment/Reconsideration Request (F-13046 (08/15)) 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. - A copy of the Explanation of Medical Benefits form, if applicable.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Decision Made by a Court, Fair Hearing, or the Wisconsin 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 Wisconsin 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. Include the following documentation as part of the request: - A complete copy of the decision notice received from the court, fair hearing, or DHS	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 request must be submitted within 455 days from the DOS. Include the following documentation as part of the request: - 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	ForwardHealth Good Faith/Timely Filing Ste 50 313 Blettner Blvd Madison WI

	the DOS: ¡ Temporary Identification Card for Express Enrollment in BadgerCare Plus ¡ Temporary Identification Card for Express Enrollment in Family Planning Only Services ¡ The response received through Wisconsin's EVS (Enrollment Verification System) from a commercial eligibility vendor ¡ The transaction log number received through WiCall ¡ The enrollment tracking number received through the ForwardHealth Portal	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. Include the following documentation as part of the request: ı A copy of the RA message that shows the ForwardHealth-initiated adjustment ı A copy of the Explanation of Medical Benefits form, if applicable	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 income maintenance 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. Include the following documentation as part of the request: ı A copy of the Explanation of Medical Benefits form, if applicable **And** ı "GR retroactive enrollment" indicated on the claim **Or** ı A copy of the letter received from the income maintenance 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 request must be submitted within 90 days of the Medicare processing date. Include the following documentation as part of the request: - A copy of the Medicare remittance information - A copy of the Explanation of Medical Benefits form, if applicable	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 request must be submitted within 90 days from the date of recoupment notification. Include the following documentation as part of the request: - A copy of the recoupment notice - An updated Explanation of Medical Benefits form, if applicable *Note:* When the reason for resubmitting is due to Medicare recoupment, ensure that the associated Medicare disclaimer code (i.e., M-7 or M-8) is included on the updated Explanation of Medical Benefits form.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Retroactive Member Enrollment into Medicaid

Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when a claim cannot be submitted within the	To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the	ForwardHealth Timely Filing

submission deadline due to a delay in the determination of a member's retroactive enrollment.	member's enrollment information. In addition, retroactive enrollment must be indicated by selecting "Retroactive member enrollment for ForwardHealth (attach appropriate documentation for retroactive period, if available)" box on the Timely Filing Appeals Request (F-13047 (08/15)) form.	Ste 50 313 Blettner Blvd Madison WI 53784

Coordination of Benefits

2

Archive Date:03/02/2020

Coordination of Benefits:Commercial Health Insurance

Topic #595

Assignment of Insurance Benefits

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

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

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

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

Topic #844

Claims for Services Denied by Commercial Health Insurance

If commercial health insurance denies or recoups payment for services that are covered by BadgerCare Plus and Wisconsin Medicaid, the provider may submit a claim for those services. To allow payment in this situation, providers are encouraged to follow the requirements (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).

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

Topic #598

Commercial Fee-for-Service

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

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

Topic #601

Definition of Commercial Health Insurance

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

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

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

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

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

Topic #602

Discounted Rates

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

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

Topic #596

Exhausting Commercial Health Insurance Sources

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

Step 1. Determine if the Member Has Commercial Health Insurance

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

If the member disputes the information as it is indicated in the EVS, the provider should submit a real-time Other Coverage Discrepancy Report via the ForwardHealth Portal or submit a completed Commercial Other Coverage Discrepancy Report (F-01159 (04/17)) form. Unless the service does not require other health insurance billing, the provider should allow at least two weeks before proceeding to Step 2.

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

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

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

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

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

Step 3. Identify Assignment of Commercial Health Insurance Benefits

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

The provider should proceed in one of the following ways:

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

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

Step 4. Bill Commercial Health Insurance and Follow Up

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

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

Step 5. Submit Claim to ForwardHealth

If only partial reimbursement is received, if the correct and complete claim is denied by commercial health insurance, or if commercial health insurance does not respond to the original and follow-up claims, the provider may submit a claim

to ForwardHealth using the appropriate other insurance indicator or complete the Explanation of Medical Benefits form, as applicable. Commercial remittance information should not be attached to the claim.

Topic #18497

Explanation of Medical Benefits Form Requirement

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

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

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

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

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

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

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

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

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

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

Topic #263

Members Unable to Obtain Services Under Managed Care Plan

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

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

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

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

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

Topic #604

Non-Reimbursable Commercial Health Insurance Services

Providers are not reimbursed for the following:

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

Topic #1249

Other Health Insurance Sources

Providers are not required by Wisconsin Medicaid to pursue other health insurance sources for Family Planning Only Services members. This helps guard the confidentiality of Family Planning Only Services members, thereby increasing access to reproductive health care for low-income members. If providers pursue other health insurance reimbursement for procedures not covered through Family Planning Only Services, they are required to obtain permission from the member.

Topic #605

Other Insurance Indicators

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

Other insurance indicators identify the status and availability of commercial health insurance. The indicators allow providers to be

reimbursed correctly when the following occur:

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

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

Note: The provider may not use OI-D or OI-Y if the member is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by ForwardHealth except for the 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.

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

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

Documentation Requirements

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

Topic #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
- In-home mental health/substance abuse treatment services for children (HealthCheck "Other Services") rendered by providers at the less than bachelor degree level, bachelor's degree level, or QTT (qualified treatment trainee) level
- Personal care 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)
- Behavioral treatment
- Blood bank services
- Chiropractic services
- Dental services
- DME (durable medical equipment) (rental or purchase), prosthetics, and hearing aids if the billed amount is over $10.00 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
- In-home mental health/substance abuse treatment services for children (HealthCheck "Other Services") rendered by providers at the master's degree level, doctoral level, and psychiatrist level
- Outpatient mental health/substance abuse services
- Mental health/substance abuse day treatment services, including child and adolescent day treatment
- Narcotic treatment services
- PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services, unless provided in a nursing home or SNF
- Physician assistant services
- Physician services, including surgery, surgical assistance, anesthesiology, or any service to a hospital inpatient (however, physician services provided to a woman whose primary diagnosis indicates a high-risk pregnancy do not require commercial health insurance billing)
- Pharmacy services for members with verified drug coverage
- Podiatry services
- PDN (private duty nursing) services
- Radiology services

- RHC (rural health clinic) services
- Skilled nursing home care, if any DOS (date of service) is within 120 days of the date of admission; if benefits greater than 120 days are available, the nursing home is required to continue to bill for them until those benefits are exhausted
- Vision services over $50, unless provided in a home, nursing home, or SNF

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

- Ophthalmology services
- Optometrist services

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

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

ForwardHealth has identified services requiring Medicare Advantage billing.

Medicare

Topic #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

Other Coverage Information

Topic #4940

After Reporting Discrepancies

After receiving a Commercial Other Coverage Discrepancy Report (F-01159 (04/17)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/2018)) form, ForwardHealth confirms the information and updates the member files.

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

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

Topic #4941

Coverage Discrepancies

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

Topic #609

Insurance Disclosure Program

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

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

Topic #610

Maintaining Accurate and Current Records

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

- Insurance Disclosure program
- Providers who submit an Commercial Other Coverage Discrepancy Report (F-01159 (04/17)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/18)) form

- Member certifying agencies
- Members

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

Topic #4942

Reporting Discrepancies

Providers are encouraged to report discrepancies to ForwardHealth by submitting the Commercial Other Coverage Discrepancy Report (F-01159 (04/17)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/2018)) form. Providers are asked to complete the form in the following situations:

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

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

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

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 Wis. Admin. Code § DHS 106.03(7).

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 608-243-0676. 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 and necessary information for providers to review and handle each claim.

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 (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 provider-based billing summary).	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.	- A Commercial Other Coverage Discrepancy Report (F-01159 (04/17)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/18)) 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 provider-based billing summary).	Send the Commercial Other Coverage Discrepancy Report form or Medicare 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 provider-based billing summary). - The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. - The amount received from the other health insurance source on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	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 provider-based billing summary). - The appropriate other insurance indicator or Medicare disclaimer code on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	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 provider-based billing summary). ▪ The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	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 provider-based billing summary). ▪ A Timely Filing Appeals Request (F-13047 (08/15)) form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 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.	▪ A Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form. ▪ **After** using the EVS to verify that the member's other coverage information has been updated, include both of the following: ▫ A claim (do **not** use the provider-based billing summary.) ▫ A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	Send the Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form to the address indicated on the form. Send the timely filing appeals request to the following address: ForwardHealth Timely Filing Ste 50 313 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 provider-based billing summary). ▪ Indicate the amount received from the commercial health insurance on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. ▪ 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	▪ A claim.	ForwardHealth

denies the provider-based billing claim.	• The appropriate other insurance indicator or Medicare disclaimer code on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. • 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.	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 billing claim.	• A claim (do **not** use the provider-based billing summary). • The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 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 website 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. - A copy of the Explanation of Medical	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567

	Benefits form, as applicable. *Note:* In this situation, ForwardHealth will initiate an adjustment if the amount of the other health insurance payment does not exceed the allowed amount (even though an adjustment request should not be submitted). However, providers (except nursing home and hospital providers) may issue a cash refund. Providers who choose this option should include a refund check but should not use the Claim Refund form.	
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. ◦ A copy of the Explanation of Medical Benefits form, as applicable. • 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	• The Provider-Based Billing Summary. • Indication that no response was received by	ForwardHealth Provider-Based Billing

provider-based billing claim.	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.	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 should add all information required by the other health insurance source 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 Wis. Admin. Code § DHS 106.03(8), 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, they 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 an accident-related diagnosis code on claims when services are provided to an accident victim. 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:03/02/2020

Covered and Noncovered Services:Codes

Topic #6717

Administration Procedure Codes for Provider-Administered Drugs

For provider-administered drugs administered to members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special MCOs (managed care organizations), all CPT (Current Procedural Terminology) administration procedure codes should be indicated on claims submitted for reimbursement to the member's MCO.

Topic #17537

Cellular/Tissue-Based Products

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

No PA (prior authorization) is required for CTP products. All non-indicated conditions are considered noncovered. More information regarding ForwardHealth's coverage policy for CTPs is available.

HCPCS Code	Description	Covered Conditions	CPT Application Code	Allowable ICD Diagnosis Code (s)	Description
		Venous leg ulcers	**15271–15278**	I83.001–I83.029	Varicose veins of lower extremity with ulcer
				I83.201–I83.229	Varicose veins of lower extremity with ulcer and inflammation
				I87.2	Venous insufficiency (chronic) (peripheral)
				I70.231*–I70.25*	Atherosclerosis of native arteries of leg with ulceration
				I70.331*–I70.749*	Atherosclerosis of bypass graft(s) of leg with ulceration

Q4101	Apligraf, per square centimeter			L97.201*–L97.529*	Non-pressure chronic ulcer
		Full-thickness neuropathic diabetic foot ulcers	**15275–15278**	E08.621, E09.621, E10.621, E11.621, E13.621	Diabetes mellitus with foot ulcer
				E08.622, E09.622, E10.622, E11.622, E13.622	Diabetes mellitus with other skin ulcer
				L97.301**–L97.529**	Non-pressure chronic ulcer of ankle, heel, or foot
Q4106	Dermagraft, per square centimeter	**Full-thickness neuropathic diabetic foot ulcers**	**15275–15278**	E08.621, E09.621, E10.621, E11.621, E13.621	Diabetes mellitus with foot ulcer
				E08.622, E09.622, E10.622, E11.622, E13.622	Diabetes mellitus with other skin ulcer
				L97.301**–L97.529**	Non-pressure chronic ulcer of ankle, heel, or foot
				C50.011–C50.019	Malignant neoplasm of nipple and areola, female
				C50.111–C50.119	Malignant neoplasm of central portion of breast, female
				C50.211–C50.219	Malignant neoplasm of upper-inner quadrant of breast, female

Q4116	Alloderm, per square centimeter	**Breast reconstructive surgery**	**15271–15274, 15777**	C50.311–C50.319	Malignant neoplasm of lower-inner quadrant of breast, female
				C50.411–C50.419	Malignant neoplasm of upper-outer quadrant of breast, female
				C50.511–C50.519	Malignant neoplasm of lower-outer quadrant of breast, female
				C50.611–C50.619	Malignant neoplasm of axillary tail of breast, female
				C50.811–C50.819	Malignant neoplasm of overlapping sites of breast, female
				C50.911–C50.919	Malignant neoplasm of breast of unspecified site, female
				C50.021–C50.029	Malignant neoplasm of nipple and areola, male
				C50.121–C50.129	Malignant neoplasm of central portion of breast, male
				C50.221–C50.229	Malignant neoplasm of upper-inner quadrant of breast, male
				C50.321–C50.329	Malignant neoplasm of lower-inner quadrant of breast, male
				C50.421–C50.429	Malignant neoplasm of upper-outer quadrant of breast, male
				C50.521–C50.529	Malignant neoplasm of lower-outer quadrant of breast, male
				C50.621–	Malignant neoplasm of

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

Q4132	GrafixPL core, per square centimeter			L97.201*–L97.529*	Non-pressure chronic ulcer
		Full-thickness neuropathic diabetic foot ulcers	**15275–15278**	E08.621, E09.621, E10.621, E11.621, E13.621	Diabetes mellitus with foot ulcer
				E08.622, E09.622, E10.622, E11.622, E13.622	Diabetes mellitus with other skin ulcer
				L97.301**–L97.529**	Non-pressure chronic ulcer of ankle, heel, or foot
Q4133	Grafix prime and GrafixPL prime, per square centimeter	**Venous leg ulcers**	**15271–15278**	I83.001–I83.029	Varicose veins of lower extremity with ulcer
				I83.201–I83.229	Varicose veins of lower extremity with ulcer and inflammation
				I87.2	Venous insufficiency (chronic) (peripheral)
				I70.231*–I70.25*	Atherosclerosis of native arteries of leg with ulceration
				I70.331*–I70.749*	Atherosclerosis of bypass graft(s) of leg with ulceration
				L97.201*–L97.529*	Non-pressure chronic ulcer
		Full-thickness		E08.621, E09.621, E10.621, E11.621, E13.621	Diabetes mellitus with foot ulcer
				E08.622,	

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

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

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

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

Topic #1265

Modifiers

Allowable modifiers for nurse midwife services are listed in the following table.

Note: ForwardHealth accepts all valid CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) modifiers. Providers should refer to CPT and HCPCS code books for information on appropriate use of modifiers.

Modifier	Description	Notes
26	Professional component	The maximum allowable fee schedule identifies procedures for which this modifier is allowable.
AQ	Physician providing a service in a HPSA (Health Professional Shortage Area) (*Note:* While the AQ modifier is defined for physicians only, any Medicaid HPSA-eligible provider may use the modifier when appropriate.)	Providers receive enhanced reimbursement when services are performed in a HPSA-eligible ZIP code.
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	Use of modifier AS is allowed under certain circumstances in which it is appropriate for a nurse midwife to be an assistant at surgery. The maximum allowable fee schedule identifies procedures for which this modifier is allowable. Wisconsin Medicaid reimburses surgical assistance services at 20 percent of the reimbursement rate allowed for the provider of the surgical procedure.
TC	Technical component	The maximum allowable fee schedule identifies procedures for which this modifier is allowable.
TH	Obstetrical treatment/services, prenatal or postpartum	If a provider renders three or fewer antepartum care visits, the provider is required to include modifier TH with the appropriate E&M service code (99201-99215 and/or 99341-99350) to indicate that the code is being used for obstetrical treatment/services. If the services are HPSA eligible, the provider should include the HPSA modifier AQ in addition to modifier TH.
TJ	Program group, child and/or adolescent	Providers are required to use modifier TJ with procedure codes 99201-99215, 99281-99285, and 99341-99350 for members 18 years of age and younger. Providers should not use the HPSA modifier AQ with modifier TJ. Providers should **only** include the HPSA modifier in situations where both of these modifiers apply.

Topic #1262

Nurse Midwife Services Allowable in Home of Member

ForwardHealth has identified nurse midwife services that are allowable in a member's home (POS (place of service) code 12 [Home]). When submitting claims or claim adjustments for nurse midwife services, providers are required to follow CPT (Current Procedural Terminology) guidelines and report only services appropriate for the POS indicated on the claim or claim adjustment.

Service	Procedure Code(s)	Allowable Modifier(s)
Home Services E&M (evaluation and management)	99341-99350*	TH, TJ, AQ
Newborn Care	99461	
Maternity Care and Delivery	59300, 59400, 59409, 59410, 59414, 59430, 59610, 59612, 59614	AQ
	59425, 59426	AQ
Immune Globulins	90384	
Supplies and Materials	99070	
Injections	J0295, J2210, J2460, J3430	

*If a provider renders three or fewer antepartum care visits to a member, the provider is required to include modifier TH (Obstetrical treatment/services, prenatal or postpartum) with the E&M service code on the separate claim/claim detail (or adjustment) for each visit. If the services are provided in a designated HPSA (Health Professional Shortage Area), the provider is also required to include modifier AQ (Physician providing a service in a HPSA). (*Note:* While the AQ modifier is defined for physicians only, any Medicaid HPSA-eligible provider may use the modifier when appropriate.) Providers are generally required to use modifier TJ (Program group, child and/or adolescent) for members 18 years of age and younger; however, providers should not use modifier TJ with HPSA modifier AQ. Providers should **only** include the HPSA modifier in situations where both of these modifiers apply.

Topic #1264

Place of Service Codes

Medicaid reimbursable nurse midwife services must be performed in an allowable POS (place of service).

Code	Description
02	Telehealth: the location where health services and health-related services are provided or received through telehealth telecommunication technology
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
19	Off Campus — Outpatient Hospital
20	Urgent Care Facility
21	Inpatient Hospital
22	On Campus — Outpatient Hospital
23	Emergency Room — Hospital
25	Birthing Center
34	Hospice
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
61	Comprehensive Inpatient Rehabilitation Facility
71	Public Health Clinic
72	Rural Health Clinic

Topic #566

Procedure Codes

Covered E&M (evaluation and management), medicine, and surgery services are identified by CPT (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) procedure codes and modifiers. ForwardHealth does not cover all services identified by CPT and HCPCS codes (e.g., fertility-related services are not covered). Other CPT and HCPCS codes have limitations (e.g., require PA (prior authorization)). These codes are updated on a quarterly basis. Providers are required to use the most current maximum allowable fee schedule in conjunction with the most current CPT and HCPCS references to determine coverage of services.

Topic #15297

Procedures Reimbursable Only as Inpatient Hospital Services

Information is available for DOS (dates of service) before January 1, 2020.

Certain surgical procedures listed below will not be reimbursed on an outpatient hospital facility claim. These services will therefore be reimbursed to professional providers only when performed in an inpatient hospital setting. These services are determined by outpatient hospital reimbursement methodology, EAPG (Enhanced Ambulatory Patient Grouper).

Outpatient hospital providers billing on a UB-04 Claim Form and physician providers billing these services on professional claims (i.e., the 837P (837 Health Care Claim: Professional) transaction or the 1500 Health Insurance Claim Form ((02/12))) are affected by this policy.

The following table lists services that are not reimbursed in an outpatient hospital setting and are based upon EAPG 993, which is developed and assigned by 3M. This list will be periodically updated.

Note: Outpatient hospital claim reimbursement may be impacted by other coding data sets including the National Correct Coding Initiative's Medically Unlikely Edits, which can cause a detail on a claim to deny.

20802	20805	20808	20816	20838	21151	21154	21155	21159	21160
21179	21180	21182	21183	21184	21188	21194	21247	21268	21344
21347	21348	21366	21423	21431	21432	21433	21435	21436	21615
21616	21630	21632	21740	21750	22010	22112	22114	22116	22216
22220	22224	22318	22319	22532	22533	22534	22548	22556	22590
22595	22610	22800	22802	22804	22808	22810	22812	22818	22819
23900	23920	24900	24920	24930	24931	24940	25900	25905	25915
25920	25924	25927	26551	26553	26554	26556	27076	27077	27078
27147	27151	27156	27158	27165	27228	27254	27258	27259	27282
27286	27290	27295	27450	27468	27519	27590	27591	27592	27596
27598	27712	27880	27881	27882	27888	28800	31230	31360	31365
31367	31368	31370	31380	31382	31390	31395	31760	31766	31770
31775	31780	31781	31786	31800	31805	32035	32036	32096	32097
32098	32100	32110	32120	32124	32140	32141	32150	32151	32160
32200	32215	32220	32225	32310	32320	32440	32442	32445	32480
32482	32484	32486	32488	32501	32503	32504	32505	32506	32507
32540	32652	32663	32665	32668	32670	32671	32672	32800	32810
32815	32820	32850	32851	32852	32853	32854	32855	32856	32900
32905	32906	32940	32997	33015	33020	33025	33030	33031	33050
33120	33130	33140	33141	33202	33203	33236	33237	33238	33243
33250	33251	33254	33255	33256	33257	33258	33259	33261	33265
33266	33300	33305	33310	33315	33320	33321	33322	33330	33335
33340	33366	33367	33368	33369	33390	33391	33404	33405	33406

33410	33411	33412	33413	33414	33415	33416	33417	33420	33422
33425	33426	33427	33430	33440	33460	33463	33464	33465	33468
33470	33471	33474	33475	33476	33478	33496	33500	33501	33502
33503	33504	33505	33506	33507	33510	33511	33512	33513	33514
33516	33517	33518	33519	33521	33522	33523	33530	33533	33534
33535	33536	33542	33545	33548	33572	33600	33602	33606	33608
33610	33611	33612	33615	33617	33619	33620	33622	33641	33645
33647	33660	33665	33670	33675	33676	33677	33681	33684	33688
33690	33692	33694	33697	33702	33710	33720	33722	33724	33726
33730	33732	33735	33736	33737	33750	33755	33762	33764	33766
33767	33768	33770	33771	33774	33775	33776	33777	33778	33779
33780	33781	33782	33783	33786	33788	33800	33802	33803	33813
33814	33820	33822	33824	33840	33845	33851	33852	33853	33858
33859	33860	33863	33864	33866	33870	33871	33875	33877	33889
33891	33910	33915	33916	33917	33920	33922	33924	33925	33926
33927	33928	33929	33930	33933	33935	33940	33944	33945	33946
33947	33948	33949	33951	33952	33953	33954	33955	33956	33957
33958	33959	33962	33963	33964	33965	33966	33969	33970	33971
33973	33974	33975	33976	33977	33978	33979	33980	33981	33982
33983	33984	33985	33986	33987	33988	33989	34001	34051	34151
34401	34451	34502	34701	34702	34703	34704	34705	34706	34707
34708	34709	34710	34711	34712	34830	34831	34832	35001	35002
35005	35013	35021	35022	35081	35082	35091	35092	35102	35103
35111	35112	35121	35122	35131	35132	35141	35142	35151	35152
35182	35189	35211	35216	35221	35241	35246	35251	35271	35276
35281	35311	35331	35341	35351	35361	35363	35508	35509	35510
35511	35515	35521	35526	35531	35533	35535	35536	35537	35538
35539	35540	35560	35563	35565	35600	35601	35606	35612	35623

35626	35631	35632	35633	35634	35636	35637	35638	35642	35645
35646	35654	35663	35671	35691	35693	35695	35840	35870	35905
35907	36660	37140	37160	37180	37181	37616	37617	37660	37788
38100	38101	38115	38381	38382	38564	38765	38770	38780	39200
39220	39501	39503	39540	39541	39560	39561	41140	41145	41153
41155	42845	42894	42961	42971	43045	43101	43107	43108	43112
43113	43116	43117	43118	43121	43122	43123	43124	43286	43287
43288	43310	43312	43313	43314	43325	43327	43328	43330	43331
43340	43341	43351	43352	43360	43361	43400	43405	43415	43425
43460	43496	43501	43502	43605	43611	43620	43621	43622	43631
43633	43634	43635	43640	43641	43800	43810	43820	43825	43840
43845	43846	43847	43850	43855	43865	44010	44021	44025	44120
44121	44126	44127	44128	44132	44133	44135	44136	44137	44140
44144	44145	44146	44147	44150	44151	44155	44156	44157	44158
44160	44202	44203	44205	44210	44211	44212	44227	44310	44314
44316	44322	44345	44604	44605	44625	44626	44660	44661	44680
44700	44701	44715	44720	44721	45110	45111	45112	45114	45116
45119	45120	45121	45126	45135	45395	45397	45540	45550	45563
45805	45825	46730	46735	46742	46744	46746	46748	47122	47125
47130	47133	47135	47140	47141	47142	47143	47144	47145	47146
47147	47350	47360	47361	47362	47381	47400	47425	47460	47612
47620	47700	47701	47711	47712	47715	47720	47721	47740	47741
47760	47765	47780	47785	47800	47802	47900	48020	48105	48145
48146	48148	48150	48152	48153	48154	48155	48500	48520	48540
48545	48547	48548	48551	48552	48554	48556	49013	49014	49020
49040	49060	49062	49605	49611	50010	50045	50065	50070	50100
50120	50125	50135	50205	50225	50236	50250	50280	50290	50300
50320	50323	50325	50327	50328	50329	50340	50360	50365	50370

50380	50500	50520	50525	50526	50540	50547	50650	50660	50722
50725	50740	50750	50770	50780	50782	50783	50785	50800	50810
50815	50820	50825	50830	50840	50860	50900	50920	50930	50940
51530	51555	51565	51570	51575	51580	51585	51590	51595	51596
51597	51800	51820	51841	51865	51900	51920	51925	51940	51960
51980	54125	54130	54135	54438	55812	55862	55865	56630	56631
56632	56633	56634	56637	56640	57110	57111	57112	57270	57280
57305	57307	57308	57311	57531	57540	57545	58140	58146	58150
58152	58180	58200	58210	58240	58275	58280	58285	58293	58822
58825	58940	58943	58950	58951	58952	58953	58954	58956	58957
58958	59136	59350	59514	59525	59852	59855	59856	59857	60254
60270	60505	60521	60522	60540	60545	60600	60605	61105	61108
61150	61151	61154	61156	61250	61253	61304	61305	61312	61313
61314	61315	61316	61320	61321	61322	61323	61340	61343	61345
61450	61458	61460	61501	61510	61512	61514	61516	61517	61518
61519	61520	61521	61522	61524	61526	61530	61531	61533	61534
61535	61536	61537	61538	61539	61540	61541	61543	61544	61545
61546	61548	61550	61552	61556	61557	61558	61559	61563	61564
61566	61567	61570	61571	61575	61580	61581	61582	61583	61584
61585	61586	61590	61591	61592	61595	61596	61597	61598	61600
61601	61605	61606	61607	61608	61611	61613	61615	61616	61618
61619	61680	61682	61684	61686	61690	61692	61697	61698	61702
61703	61705	61708	61710	61711	61735	61870	62005	62010	62100
62115	62117	62120	62121	62140	62141	62142	62143	62145	62146
62147	62148	62163	62164	62180	62190	62192	62200	62201	63050
63051	63077	63078	63085	63086	63087	63088	63090	63091	63101
63102	63103	63170	63172	63173	63180	63182	63185	63190	63194
63195	63196	63197	63198	63199	63200	63250	63251	63252	63265

63266	63268	63270	63271	63275	63276	63277	63278	63280	63281
63282	63283	63285	63286	63287	63290	63300	63301	63302	63303
63304	63305	63306	63307	63308	63700	63702	63704	63706	63740
64755	64760	64809	65273	69535	69554	92970	92992	92993	99184
99190	99191	99192	99462	99468	99469	99471	99472	99475	99476
99477	99478	99479	99480						

Topic #18198

Sleep Medicine Testing

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

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

Allowable Facility-Based Sleep Studies and Polysomnography Procedure Codes

CPT (Current Procedural Terminology) Procedure Code	Description
95805 Multiple Sleep Latency Test/Maintenance of Wakefulness Test	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness
95806 Unattended Sleep Study — Type III	Sleep study, unattended, simultaneous recording of heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)
95807 In-Lab Sleep Study (PSG)	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist
95808 In-Lab Sleep Study (PSG)	Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist
95810 In-Lab Sleep Study (PSG)	age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95811 In-Lab Sleep Study (PSG)	age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist

95782 In-Lab Sleep Study (PSG)	younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95783 In-Lab Sleep Study (PSG)	younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist

Allowable Home-Based Sleep Studies Procedure Codes

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

Topic #643

Unlisted Procedure Codes

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

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

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

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

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

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

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

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

Topic #830

Valid Codes Required on Claims

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

Code Validity

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

Code Specificity for Diagnosis

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

Covered Services and Requirements

Topic #1261

An Overview

Nurse midwives are limited to providing the following categories of covered services:

- Family planning services
- Laboratory services
- Obstetric services
- Office and outpatient visits
- TB (tuberculosis)-related services

The practice of nurse midwifery means "the management of women's health care, pregnancy, childbirth, postpartum care for newborns, family planning, and gynecological services consistent with the standards of practice of the American College of Nurse-Midwives and the education, training, and experience of the nurse-midwife" (Wis. Stats. Board of Nursing § 441.15).

All nurse midwife services must be fully documented in the member's medical record and available for inspection or review by the Wisconsin DHS (Department of Health Services) auditors.

Topic #1244

Service Area

Nurse midwives should use the Nurse Midwife service area of the Online Handbook in conjunction with the Physician service area. The Nurse Midwife service area includes the following limited information that applies to fee-for-service Medicaid-enrolled nurse midwives:

- Enrollment, including protocols and collaborative agreements
- Covered services, including obstetric services
- Newborn reporting and screenings
- Reimbursement

The Physician service area includes information about the following:

- E&M (evaluation and management) services
- Laboratory services
- Medicine services
- Radiology services
- Surgery services

Topic #17517

Cellular/Tissue-Based Products

ForwardHealth covers CTPs (cellular/tissue-based products) in limited circumstances where evidence of efficacy is strong. ForwardHealth only covers CTPs for wound treatment for members with neuropathic diabetic foot ulcers, non-infected venous

leg ulcers, or members who are undergoing breast reconstruction surgery following a breast cancer diagnosis.

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

Product Coverage Review Policy

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

Topic #771

Certificate of Need for Transportation

ForwardHealth covers SMV (specialized medical vehicle) services if the transportation is to and from a facility where the member receives Medicaid-covered services and the member meets the criteria for SMV services. The following are criteria for SMV services:

- A member must be indefinitely disabled, legally blind, or temporarily disabled.
- A member must have a medical condition that contraindicates safe travel by common carrier such as bus, taxi, or private vehicle.

If a member meets the criteria, a physician, physician assistant, nurse practitioner, or nurse midwife should complete a Certification of Need for Specialized Medical Vehicle Transportation (F-01197 (06/09)) form.

Inconvenience or lack of timely transportation are not valid justifications for the use of SMV transportation. The presence of a disability does not by itself justify SMV transportation.

The medical provider gives a copy of the completed form to the member who then gives the form to the SMV provider. The medical provider does not need to keep a copy of the completed form on file, but they are required to document the medical condition necessitating SMV transportation in the member's medical record.

Physicians are required to complete a new Certification of Need for Specialized Medical Vehicle Transportation form upon expiration. For members who are indefinitely disabled, the form is valid for three years (36 months) from the date the medical provider signed the form. For members who are temporarily disabled, the form is valid for the period indicated on the form, which must not exceed 90 days from the date the medical provider signed the form.

Medical providers must not complete the forms retroactively for SMV providers or members.

Providers may not charge members for completing the Certification of Need for Specialized Medical Vehicle Transportation form. Wisconsin Medicaid will reimburse providers at the lowest level E&M (evaluation and management) CPT (Current Procedural Terminology) procedure code if the member is in the office when the form is completed and no other medical service is provided.

Topic #44

Definition of Covered Services

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

Topic #85

Emergencies

Certain program requirements and reimbursement procedures are modified in emergency situations. Emergency services are defined in Wis. Admin. Code § DHS 101.03(52), 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-U.S. citizens may be eligible for covered services in emergency situations.

Topic #84

Medical Necessity

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

Topic #19797

Evaluation and Management Services

It is not medically necessary or appropriate to bill a higher level of E&M (evaluation and management) service when a lower level of service is warranted.

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 #5677

Not Otherwise Classified Procedure Codes

Providers who indicate procedure codes such as J3490 (Unclassified drugs), J3590 (Unclassified biologics), or J9999 (Not otherwise classified, antineoplastic drugs) on claims for NOC (not otherwise classified) drugs must also indicate the following on the claim:

- The NDC (National Drug Code) of the drug dispensed
- The name of the drug
- The quantity billed
- The unit of issue (i.e., F2, gr, me, ml, un)

If this information is not included on the claim or if there is a more specific HCPCS (Healthcare Common Procedure Coding System) procedure code for the drug, the claim will be denied. Compound drugs that do not include a drug approved by the FDA (Food and Drug Administration) will be denied.

Providers are required to comply with the requirements of the federal DRA (Deficit Reduction Act) of 2005 and submit NDCs with HCPCS and CPT (Current Procedural Terminology) procedure codes for provider-administered drugs. Section 1927(a)(7)(C) of the Social Security Act requires NDCs to be indicated on all claims submitted to ForwardHealth for covered outpatient drugs, including Medicare crossover claims.

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 #5697

Provider-Administered Drugs

A provider-administered drug is either an oral, injectable, intravenous, or inhaled drug administered by a physician or a designee of the physician (e.g., nurse, nurse practitioner, physician assistant).

Providers may refer to the maximum allowable fee schedules for the most current HCPCS (Healthcare Common Procedure Coding System) and CPT (Current Procedural Terminology) procedure codes for provider-administered drugs and reimbursement rates.

Provider-administered drugs carve-out policy is defined to include the following procedure codes:

- Drug-related "J" codes
- Drug-related "Q" codes
- Certain drug-related "S" codes

The Provider-Administered Drugs Carve-Out Procedure Codes table indicates the status of procedure codes considered under the provider-administered drugs carve-out policy. This table provides information on Medicaid and BadgerCare Plus coverage status as well as carve-out status based on POS (place of service).

Note: The table will be revised in accordance with national annual and quarterly HCPCS code updates.

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.

All fee-for-service policies and procedures related to provider-administered drugs, including copayment, cost sharing, diagnosis restriction, PA (prior authorization), and pricing policies, apply to claims submitted to fee-for-service for members enrolled in an MCO (managed care organization).

Provider-administered drugs and related services for members enrolled in PACE (Program of All-Inclusive Care for the Elderly) are provided and reimbursed by the special managed care program.

Note: For Family Care Partnership members who are not enrolled in Medicare (Medicaid-only members), outpatient drugs (excluding diabetic supplies), provider-administered drugs, compound drugs (including parenteral nutrition), and any other drugs requiring drug utilization review are covered by fee-for-service Medicaid. All fee-for-service policies, procedures, and requirements apply for pharmacy services provided to Medicaid-only Family Care Partnership members. Dual eligibles (enrolled in Medicare and Medicaid) receive their outpatient drugs through their Medicare Part D plans. However, if the member's Part D plan does not cover the outpatient drug, these dually eligible members may access certain Medicaid outpatient drugs that are excluded or otherwise restricted from Medicare coverage through fee-for-service Medicaid. For these drugs, fee-for-service policies would apply.

Obtaining Provider-Administered Drugs

To ensure the content and integrity of the drugs administered to members, prescribers are required to obtain all drugs that will be administered in their offices. Prescribers may obtain a provider-administered drug from a pharmacy provider if the drug is delivered directly from the pharmacy to the prescriber's office. Prescribers may also obtain a drug to be administered in the prescriber's office from a drug wholesaler or direct purchase. Pharmacy providers should not dispense a drug to a member if the drug will be administered in the prescriber's office.

Topic #824

Services That Do Not Meet Program Requirements

As stated in Wis. Admin. Code § DHS 107.02(2), 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 Wis. Admin. Code § DHS 106.03, 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 Wisconsin 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 Wis. Admin. Code ch. DHS 105
- 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 DHS

Topic #18177

Sleep Medicine Testing

Sleep medicine testing involves six or more hours of continuous and simultaneous monitoring and recording of various

physiological and pathophysiological parameters of sleep with physician review, interpretation, and reporting. Polysomnography is distinguished from facility-based sleep studies and home-based sleep studies by the inclusion of sleep staging. Type IV sleep testing devices are not covered by ForwardHealth.

Coverage Requirements

Facility-Based Sleep Studies and Polysomnography

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

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

Home-Based Sleep Studies

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

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

Coverage Limitations for Sleep Medicine Testing

ForwardHealth does not cover the following:

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

Topic #510

Telehealth

Information is available for DOS (dates of service) before January 1, 2020.

ForwardHealth allows certain covered services to be provided via telehealth (also known as "telemedicine"). Telehealth enables a provider who is located at a distant site to render the service remotely to a member located at an originating site using a combination of interactive video, audio, and externally acquired images through a networking environment.

Allowable Providers

The following types of providers may be reimbursed for providing telehealth services at a distant site:

- Audiologists

- Nurse midwives
- Nurse practitioners
- Ph.D. psychologists
- Physician assistants
- Physicians
- Psychiatrists
- Professionals providing services in mental health or substance abuse programs certified by the DQA (Division of Quality Assurance)

Allowable Originating Sites

The member must be at one of the following originating sites during the telehealth service:

- Hospitals, including emergency departments
- Office/clinic
- Skilled nursing facility

Requirements and Restrictions

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

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

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

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

Noncovered Services

The following are not covered as telehealth services:

- Telephone conversations
- Written electronic communications (e.g., email, texts)
- Store and forward services (defined as the asynchronous transmission of medical information to be reviewed at a later time by a provider at a distant site)
- Services that are not covered when delivered face-to-face

Claims Submission and Reimbursement for Distant Site Providers

Claims for services provided via telehealth by distant site providers must be billed with the same procedure code as would be used for a face-to-face encounter along with HCPCS (Healthcare Common Procedure Coding System) modifier GT (via interactive audio and video telecommunication systems).

Claims must also include POS (place of service) code 02 (Telehealth: the location where health services and health-related services are provided or received through telehealth telecommunication technology). ForwardHealth reimburses the service rendered by distant site providers at the same rate as when the service is provided face-to-face.

Ancillary Providers

Claims for services provided via telehealth by distant site ancillary providers should continue to be submitted under the supervising physician's NPI (National Provider Identifier) using the lowest appropriate level office or outpatient visit procedure code or other appropriate CPT (Current Procedural Terminology) code for the service performed. These services must be provided under the direct on-site supervision of a physician who is located at the same physical site as the ancillary provider and must be documented in the same manner as services that are provided face to face.

Pediatric and Health Professional Shortage Area-Eligible Services

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

Claims Submission and Reimbursement for Originating Site Facility Fee

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

Providers who bill on a professional claim form should bill Q3014 with a POS code that represents where the member is located during the service. The POS must be a ForwardHealth-allowable originating site for procedure code Q3014 in order to be reimbursed for the originating site fee. The originating site fee is reimbursed based on a maximum allowable fee.

Providers who bill on an institutional claim form should bill Q3014 as a separate line item with the appropriate revenue code. ForwardHealth will reimburse these providers for the facility fee based on the provider's standard reimbursement methodology.

Documentation Requirements

All services provided via telehealth must be thoroughly documented in the member's medical record in the same manner as services provided face-to-face. As a reminder, documentation for originating sites must support the member's presence in order to submit a claim for the originating site facility fee. In addition, if the originating site provides and bills for services in addition to the originating site facility fee, documentation in the member's medical record should distinguish between the unique services provided.

Telestroke Services

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

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

Claims Submission for Telestroke Services

Providers are required to use CPT consultation and E&M (evaluation and management) procedure codes when billing telestroke

services. Telestroke services are subject to the same enrollment policy, coverage policy, and billing policy as telehealth services. All other services rendered by the provider at the originating site, and by any providers to which the member is transferred, should be billed in the same manner as visits or admissions that do not involve telehealth services.

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

Additional Policy for Certain Types of Providers

Out-of-State Providers

ForwardHealth policy for services provided via telehealth by out-of-state providers is the same as ForwardHealth policy for services provided face-to-face by out-of-state providers. Out-of-state providers who do not have border status enrollment with Wisconsin Medicaid are required to obtain PA before providing services via telehealth to BadgerCare Plus or Medicaid members.

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

Certified Mental Health and Substance Abuse Treatment Providers

Programs and services certified by the DQA in accordance with Wis. Admin. Code chs. DHS 34, 35, 36, 40, 61, 63, or 75 to provide mental health and substance abuse treatment programs or services are required to meet telehealth certification requirements if they plan to provide services via telehealth.

Community Health Centers, Tribal Federally Qualified Health Centers, and Rural Health Clinics

CHCs (community health centers), tribal FQHCs (federally qualified health centers), and RHCs (rural health clinics) may serve as originating site and distant site providers for telehealth services.

Distant Site

Tribal FQHCs and RHCs may report services provided via telehealth on the cost settlement report when the FQHC or RHC served as the distant site and the member is an established patient of the tribal FQHC or RHC at the time of the telehealth service.

CHCs may not report services provided via telehealth as an encounter. Instead, CHCs should submit claims for distant site services on a professional claim form and will be reimbursed in accordance with the maximum allowable fee schedule.

Originating Site

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

For CHCs, originating site services should be billed, but no reimbursement will be issued as all costs for providing originating site services have already been incorporated into the PPS (prospective payment system) rates for CHCs. Claims billed by CHCs for originating site services may be used for future rate setting purposes.

Allowable Services

ForwardHealth only covers telehealth delivery of individual services. For those procedure codes that can be used for either individual or group services, providers may not submit claims for telehealth delivery of group services. Allowable providers may

be reimbursed, as appropriate, for the following services (and applicable procedure codes) provided through telehealth.

Note: The use of E&M codes is subject to E&M documentation guidelines.

Type of Service	Procedure Codes
Adult Mental Health Day Treatment Services	H2012 (for individual services only)
Audiology Services	92550, 92585, 92586, 92587, 92588
Child/Adolescent Day Treatment Services (HealthCheck "Other Services")	H2012 (for individual services only)
Community Support Program Services	H0039 (for individual services only)
Comprehensive Community Services	H2017 (for individual services only)
Crisis Intervention Services	S9484
End-Stage Renal Disease-Related Services	90951-90952, 90954-90958, 90960-90961, 90967-90970
Health and Behavior Assessment/Intervention	96156, 96158-96159, 96167, 96170-96171
Initial Inpatient Consultations	99251-99255
Office or Other Outpatient Services	99201-99205, 99211-99215*
Office or Other Outpatient Consultations	99241-99245*
Outpatient Mental Health Services (Evaluation, Psychotherapy)	90785, 90791-90792, 90832-90834, 90836-90840, 90845-90847, 90849, 90875, 90876, 90887
Outpatient Substance Abuse Services	H0022, H0047, T1006
Substance Abuse Day Treatment	H2012 (for individual services only)

* Telehealth services that are medical in nature and would otherwise be coded as an office visit or consultation evaluation and management visit are covered for members residing in a skilled nursing facility that meets all originating site requirements. Nursing Facility Service Assessments are not covered as telehealth services (e.g. 99304-99318). Domiciliary, Rest Home, or Custodial Care Services and Oversight Services (codes 99324-99340) are not allowable as telehealth services.

Evaluation and Management

Topic #3414

Documentation

BadgerCare Plus and Wisconsin Medicaid have adopted the federal CMS (Centers for Medicare and Medicaid Services) 1995 and 1997 Documentation Guidelines for Evaluation and Management Services in combination with BadgerCare Plus and Wisconsin Medicaid policy for E&M (evaluation and management) services. Providers are required to present documentation upon request indicating which of the guidelines or BadgerCare Plus policies were utilized for the E&M procedure code that was billed.

The documentation in the member's medical record for each service must justify the level of the E&M code billed. Unless otherwise described in BadgerCare Plus or Wisconsin Medicaid policy, providers should follow CMS documentation guidelines. Providers may access the CMS documentation guidelines on the CMS website. BadgerCare Plus and Medicaid policy information can be found in service-specific areas of the Online Handbook.

Documentation Requirements

Providers are required to meet the following documentation requirements for E&M services:

- The documentation must accurately reflect the services rendered and support the level of service submitted on the claim.
- Providers are required to document the E&M service at the time the service is provided or as soon as reasonably possible after the service is provided in order to maintain an accurate medical record. All documentation must be complete prior to submission of the claim. Before a service is reimbursed, the provider is required to meet all recordkeeping requirements, according to Wis. Admin. Code § DHS 106.02(9)(f).
- Providers should only consider medically relevant documentation in determining the appropriate procedure code to bill. The E&M level of service chosen by the provider should not be solely based on the amount of documentation recorded.

All providers who receive reimbursement from Wisconsin Medicaid are required to maintain records that fully document the basis of charges upon which all claims for payment are made, according to Wis. Admin. Code § DHS 106.02(9)(a).

ForwardHealth recognizes certain corrections or changes to a member's medical record when amended legally to accurately reflect the member's medical history. However, if these corrections or changes appear in the medical record following reimbursement determination, only the original medical record will be considered when determining if the reimbursement of services billed was appropriate.

No documentation iterations or section of iterations may be destroyed, deleted, whited-out or rendered illegible. When using a medical EHR (electronic health record) or medical paper record, the provider must be able to generate an unadulterated audit trail that can verify the information and indicate which actions occurred, when they occurred, and by whom. The date, time, member identification, and user identification must be recorded when information within the record is created, modified, or accessed. Paper-based records must redact previous entries by putting a line through the notation and having it initialed and dated by the user.

Pre-Loaded Text for Electronic Health Records

When using EHR, it is acceptable for the provider to use pre-loaded text or other pre-generated text as long as the required personal documentation is in a secured (password-protected) system and the documentation reflects the actual service rendered. For any pre-loaded or other pre-generated text, the documentation must support that the provider verified the information as part

of the professional service rendered.

Personal changes to the pre-loaded or pre-generated text made by the provider generally supports that the information has been verified as part of the professional service billed. Phrases that cannot be verified are not acceptable. Examples of non-verifiable types of phrases include the following:

- The complete ROS (Review of Systems) was performed in detail and was negative.
- The 14-point ROS was performed in detail with the member and was negative.
- All other 14 systems are negative.

Furthermore, only medically necessary elements in the pre-loaded or other pre-generated text should be used to determine the level of service reported (i.e., pertinent to the presenting complaint).

The EHR record must be signed by the renderer of the service.

When Time is Considered the Key or Controlling Factor to Select the Evaluation and Management Level

When time is considered the key or controlling factor to qualify for a particular level of E&M services, the extent of the counseling and/or coordination of care must be documented in the medical record. ForwardHealth follows guidelines as outlined in *Current Procedural Terminology* Evaluation and Management Services Guidelines. The following are ForwardHealth documentation requirements for counseling and/or coordination of care when time is considered the key or controlling factor:

- When counseling and/or coordination of care is the key factor to determining the level of service, documentation needs to support the amount of time spent in discussion and detail the context of the conversation and any decisions made or actions that will result based on this counseling.
- When documentation supports that counseling dominated more than 50 percent of the total visit, time may be used to qualify for a particular level of E&M services. However, the use of time with counseling as the key controlling factor for the level of service should be infrequent.
- Documentation must support counseling as above and beyond the usual discussion of the assessment and plan.

HealthCheck "Other Services"

Topic #22

Definition of HealthCheck "Other Services"

HealthCheck is the term used for EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) in Wisconsin. The HealthCheck benefit provides periodic, comprehensive health screening exams (also known as "well child checks"), as well as interperiodic screens, outreach and case management, and additional medically necessary services (referred to as HealthCheck "Other Services") for members under 21 years of age.

Wisconsin Medicaid covers most diagnostic and intervention services a member may need. However, federal law requires that states provide any additional health care services that are coverable under the federal Medicaid program and found to be medically necessary to treat, correct, or reduce illnesses and conditions discovered regardless of whether or not the service is covered in a state's Medicaid program. HealthCheck "Other Services" is Wisconsin's term for this federal requirement.

The requested service must be allowable under federal Medicaid law, per § 1905(a) of the Social Security Act, and must be medically necessary and reasonable for the member to be covered by Wisconsin Medicaid, per Wis. Admin. Code § DHS 107.02(3)(e). Most HealthCheck "Other Services" require PA (prior authorization) per Wis. Admin. Code § DHS 107.02.

Topic #1

Prior Authorization for HealthCheck "Other Services"

Providers submitting PA (prior authorization) requests for HealthCheck "Other Services" should review the two types of PA requests. The following types of PA requests have their own submission requirements:

- Requests for exceptions to coverage limitations
- Requests for federally allowable Medicaid services not routinely covered by Wisconsin Medicaid

PA Submission Requirements for Exceptions to Coverage Limitations

HealthCheck "Other Services" may additionally cover established Medicaid health care services that are limited in coverage for members under 21 years of age.

If a PA request is submitted requesting additional coverage for a benefit where there is established policy, the request is automatically processed under the HealthCheck "Other Services" benefit to evaluate whether the requested service is likely to correct or ameliorate the member's condition, including maintaining current status or preventing regression.

Examples of coverage limitations include service amounts that are prohibited by policy, or the requested service is not expected to result in a favorable improvement in the member's condition or diagnosis.

Every PA request for a member under age 21 is first processed according to standard Medicaid guidelines and then reviewed under HealthCheck "Other Services" guidelines. For these reasons, providers do **not** need to take additional action to identify the PA request as a HealthCheck "Other Services" request.

If an established benefit will be requested at a level that exceeds Wisconsin Medicaid coverage limits, in addition to the required PA documentation detailed in the appropriate service area of the Online Handbook, the request should provide:

- The rationale detailing why standard coverage is not considered acceptable to address the identified condition.
- The rationale detailing why the requested service is needed to correct or ameliorate the member's condition.

PA Submission Requirements for Services Not Routinely Covered by Wisconsin Medicaid

HealthCheck "Other Services" allows coverage of health care services that are not routinely covered by Wisconsin Medicaid, but are federally allowable and medically necessary to maintain, improve, or correct the member's physical and mental health, per § 1905(a) of the Social Security Act. These HealthCheck "Other Services" require PA since the determination of medical necessity is made on a case-by-case basis depending on the needs of the member.

If a PA request is submitted requesting coverage for a service that does not have established policy and is not an exception to coverage limitations, the provider is required to identify the PA as a HealthCheck "Other Services" request by **checking the HealthCheck "Other Services" box** and submit the following information:

- A current, valid order or prescription for the service being requested:
  - Prescriptions are valid for 12 or fewer months from the date of the signature (depending on the service area).
  - Updated prescriptions may be required more frequently for some benefits.
- A completed PA/RF (Prior Authorization Request Form, F-11018 (05/13)), for most service areas, including the following:
  - For Element 1, **check the HealthCheck "Other Services" box.**
  - For Element 19, enter the procedure code that most accurately describes the service, even if the code is not ordinarily covered by Wisconsin Medicaid. Unlisted procedure codes can be requested if the service is not accurately described by existing procedure codes.
  - For Element 20, enter informational procedure code modifier EP (Service provided as part of Medicaid early periodic screening diagnosis and treatment [EPSDT] program) to indicate that the service is requested as a HealthCheck "Other Services" benefit.
  - For Element 22, include the description of the service.
- A completed PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/12)), or PA/HIAS1 (Prior Authorization Request for Hearing Instrument and Audiological Services, F-11020 (05/13)) when the PA/RF is not applicable
- A PA attachment form(s) for the related service area, if known, or clinical documentation substantiating the medical necessity of the requested procedure code and:
  - The rationale detailing why services typically covered by Wisconsin Medicaid are not considered acceptable to address the identified condition or why services were discontinued.
  - The rationale detailing why the requested service is needed to correct or ameliorate the member's condition.

  Note: Providers may call Provider Services to determine the appropriate PA attachment.

- Evidence the requested service is clinically effective and not harmful (If the requested service is new to Wisconsin Medicaid, additional documentation regarding current research and/or safety of the intervention may be submitted.)
- The MSRP (manufacturer's suggested retail price) for requested equipment or supplies
- The 11-digit NDC (National Drug Code) for any dispensed OTC (over-the-counter) drugs on pharmacy PA requests

Providers may call Provider Services for more information about HealthCheck "Other Services."

If the PA request is incomplete or additional information is needed to substantiate the necessity of the requested service, the PA request will be returned to the provider. **A return for more information is not a denial.**

Topic #41

Requirements

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

- The service is provided to a member who is under 21 years of age.
- The service is coverable under federal Medicaid law.
- The service is medically necessary and reasonable.
- The service is prior authorized before it is provided.
- Services currently available 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 the authorized amount is reasonable and maintains the preventive intent of the HealthCheck benefit.

HealthCheck "Other Services" does not include reimbursement in excess of ForwardHealth published maximum allowable fees.

All PA (prior authorization) requests must follow NCCI (National Correct Coding Initiative) guidelines.

Mental Health and Substance Abuse Screening for Pregnant Women

Topic #4442

An Overview

Definition of the Benefit

This benefit is for pregnant women enrolled in BadgerCare Plus and Wisconsin Medicaid. All policies and procedures are the same for BadgerCare Plus and Wisconsin Medicaid unless otherwise specified. Women enrolled in an HMO must receive the services through the HMO. These services do not require PA (prior authorization) and are not subject to copayment under BadgerCare Plus and Wisconsin Medicaid.

The purpose of this benefit is to identify and assist pregnant women at risk for mental health or substance abuse problems during pregnancy. The benefit has two components:

- Screening for mental health (e.g., depression and/or trauma) and/or substance abuse problems
- Brief preventive mental health counseling and/or substance abuse intervention for pregnant women identified as being at risk for experiencing mental health or substance abuse disorders

These are preventive services available to members with a verified pregnancy. These services are not intended to treat women previously diagnosed with a mental health or substance abuse disorder or to treat women already receiving treatment through mental health, substance abuse, or prenatal care coordination services.

The mental health screening and preventive counseling are designed to prevent mental health disorders from developing or worsening in severity during the pregnancy and the postpartum period. The substance abuse screening and intervention services are designed to help women stay alcohol and drug free during the pregnancy.

Women identified through the screening process as likely to be experiencing mental health disorders and women identified as likely to be dependent on alcohol or other drugs should be referred to an appropriate enrolled mental health or substance abuse program.

Mental Health and Substance Abuse Screening

Providers are required to use an in-depth evidence-based tool to identify women at risk for mental health, substance abuse, or trauma-related problems; however, there is no requirement for a specific screening tool.

Mental health screening tools available to providers include the following:

- EPDS (Edinburgh Postnatal Depression Scale)
- BDI-II (Beck Depression Inventory-II)
- CES-D (Center for Epidemiologic Studies Depression Scale)
- The nine item depression scale of the PHQ-9 (Patient Health Questionnaire)

Substance abuse screening tools available to providers include the following:

- The 5-Ps Prenatal Substance Abuse Screen for Alcohol, Drugs, and Tobacco

- T-ACE (Tolerance, Annoyance, Cut down, Eye opener) screen
- TWEAK (Tolerance, Worry, Eye opener, Amnesia, Cut down) screen
- The ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test)

Preventive Mental Health Counseling and Substance Abuse Intervention

Brief preventive mental health counseling and substance abuse intervention services are covered for pregnant women who are identified through the use of an evidence-based screening tool as being at risk for mental health or substance abuse disorders.

Providers are required to use effective strategies for the counseling and intervention services although BadgerCare Plus and Wisconsin Medicaid are not endorsing a specific approach.

Examples of effective strategies for treatment include the following:

- SBIRT (Screening, Brief Intervention and Referral to Treatment)
- My Baby & Me (a program that addresses alcohol cessation in pregnant women using specific intervention and counseling strategies)

Topic #4446

Coverage Limitations

Mental Health and Substance Abuse Screening

The screening (HCPCS (Healthcare Common Procedure Coding System) procedure code H0002 with modifier "HE" or "HF") is not considered part of the mental health and substance abuse services available under BadgerCare Plus or Wisconsin Medicaid. The screening does not require PA (prior authorization) and is not counted towards any service limitations or PA thresholds for those services.

Preventive Mental Health Counseling and Substance Abuse Intervention

The counseling/intervention services (HCPCS procedure code H0004 with modifier "HE" or "HF") are limited to four hours (or 16 units of service, each unit equivalent to 15 minutes) per member per pregnancy. If a member receives both preventive mental health counseling and substance abuse intervention services, the hours of both services count toward the four-hour limit. Additionally, only one hour (up to four units of service) can be billed on one DOS (date of service). The counseling and intervention services must be provided on the same DOS or on a later DOS than the screening.

These services are covered during the pregnancy and up to 60 days postpartum.

These services are not considered part of the mental health and substance abuse services available under BadgerCare Plus or Wisconsin Medicaid and are not counted towards any service limitations or PA thresholds for those services.

Topic #4444

Documentation Requirements

Providers are required to retain documentation that the member receiving these services was pregnant on the DOS (date of service). Providers are also required to keep a copy of the completed screening tool(s) in the member's file. If an individual other than a certified or licensed health care professional provides services, the provider is required to retain documents concerning that individual's education, training, and supervision.

Topic #4443

Eligible Providers

Early detection of potential mental health, trauma, or substance abuse problems is crucial to successfully treating pregnant women. It is also important for women to obtain referrals for follow-up care. In order to accomplish these goals, BadgerCare Plus and Wisconsin Medicaid are allowing a wide range of providers to administer these services.

The screening, counseling, and intervention services must be provided by a certified or licensed health care professional or provided by an individual under the direction of a licensed health care professional. In addition to meeting the supervision requirement, individuals who are not licensed health care professionals must have appropriate training or a combination of training and work experience in order to administer any of these services.

Providers Eligible for Reimbursement of Mental Health and Substance Abuse Screening, Preventive Mental Health Counseling, and Substance Abuse Intervention Services for Pregnant Women

The following table lists provider types eligible for reimbursement for administering mental health and substance abuse screening, preventive mental health counseling, and substance abuse intervention services for pregnant women enrolled in BadgerCare Plus and Wisconsin Medicaid.

Provider Type	Mental Health or Substance Abuse Screening (H0002 with modifier "HE" or"HF")*	Mental Health Preventive Counseling (H0004 with modifier "HE")*	Substance Abuse Intervention (H0004 with modifier "HF")*
Physicians and physician assistants	Allowed	Allowed	Allowed
Psychiatrists	Allowed	Allowed	Allowed
Psychologists (Ph.D.) in outpatient mental health or substance abuse clinics	Not allowed	Allowed	Allowed
Master's-level psychotherapists in outpatient mental health or substance abuse clinics	Not allowed	Allowed	Allowed
Master's-level psychotherapists with a substance abuse certificate in outpatient mental health or substance abuse clinics	Not allowed	Not allowed	Allowed
AODA counselors in outpatient mental health or substance abuse clinics	Not allowed	Not allowed	Allowed
Advanced practice nurse prescribers with psychiatric specialty	Allowed	Allowed	Allowed
Nurse midwives	Allowed	Not allowed	Allowed

Nurse practitioners	Allowed	Allowed	Allowed
Prenatal care coordination agencies	Allowed	Not allowed	Allowed
Crisis intervention agencies	Allowed	Allowed	Allowed
HealthCheck providers (not including Case Management Only agencies)	Allowed	Not allowed	Allowed

* This table includes the HCPCS (Healthcare Common Procedure Coding System) procedure codes and modifiers that correspond with the screening, counseling, and intervention services.

Topic #4445

Procedure Codes and Modifiers

The following tables list the HCPCS (Healthcare Common Procedure Coding System) procedure codes and applicable modifiers that providers are required to use when submitting claims for mental health and substance abuse screening, preventive mental health counseling, and substance abuse intervention services for pregnant women enrolled in BadgerCare Plus or Wisconsin Medicaid. Not all providers may be reimbursed for a particular service.

Mental Health and Substance Abuse Screening and Preventive Counseling/Intervention Services for Pregnant Women					
Procedure Code	**Description**	**Required Modifier**	**Limitations**	**Allowable ICD (International Classification of Diseases) Diagnosis**	**Allowable Place of Service**
H0002 Mental Health and Substance Abuse Screening	Behavioral health screening to determine eligibility for admission to treatment program (Unit equals one, regardless of time)	HE (Mental health program) or HF (Substance abuse program)	No limit to the number of screenings per pregnancy.	Z36.9 (Encounter for antenatal screening unspecified)	03, 04, 05, 06, 07, 08, 11, 12, 13, 14, 15, 19, 20, 21*, 22, 23, 25, 26, 49, 50, 51, 56, 57, 60, 61, 71, 72
H0004 Preventive Mental Health	Behavioral health counseling and therapy, per 15	Required HE (Mental health program)	Limited to 16 units per member per pregnancy. Only four units of service are allowed per DOS.	Z71.89 (Other	03, 04, 05, 06, 07, 08, 11, 12, 13, 14, 15, 19, 20, 21*, 22,

Counseling and Substance Abuse Intervention	minutes (Unit equals 15 minutes)	HF (Substance abuse program)	A screening (H0002 with modifier HE or HF) must be administered on or before the DOS for this procedure.	specified counseling)	23, 25, 26, 49, 50, 51, 56, 57, 60, 61, 71, 72

* POS (place of service) code 21 (inpatient hospital) is not allowed for substance abuse counselors and master's-level mental health providers.

Noncovered Services

Topic #68

Definition of Noncovered Services

A noncovered service is a service, item, or supply for which reimbursement is not available. Wis. Admin. Code § DHS 101.03 (103) and ch. 107 contain more information about noncovered services. In addition, Wis. Admin. Code § DHS 107.03 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.
- If a member needs assistance in obtaining transportation to a medical appointment, encourage the member to call MTM, Inc. (Medical Transportation Management, Inc.) for NEMT (non-emergency medical transportation). Most Medicaid and BadgerCare Plus members may receive NEMT services through MTM, Inc. if they have no other way to receive a ride. 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

Obstetric Care

Topic #1260

An Overview

Wisconsin Medicaid offers providers choices of how and when to file claims for obstetric care. Providers may choose to submit claims using one of the following:

- Separate obstetric component procedure codes as they are performed
- An appropriate global obstetric procedure code with the date of delivery as the DOS (date of service)

Wisconsin Medicaid will not reimburse individual antepartum care, delivery, or postpartum care codes if a provider also submits a claim for global obstetric care codes for the same member during the same pregnancy or delivery. The exception to this rule is in the case of multiple births where more than one delivery procedure code may be reimbursed.

Topic #7757

Cesarean Sections

Nationally, the number of scheduled, elective cesarean sections has increased steadily. To ensure that the Wisconsin DHS (Department of Health Services) is reimbursing providers for performing cesarean sections only in instances where such action is medically indicated, DHS is reimbursing providers for elective cesarean sections at the same rate as for a vaginal delivery. Reimbursement rates for non-elective cesarean sections are not affected by this policy.

Elective Cesarean Sections

The reimbursement rate for elective cesarean sections is the same as for vaginal deliveries for the following procedure codes:

- 59510 (Routine obstetric care including antepartum care, cesarean delivery, and postpartum care)
- 59514 (Cesarean delivery only)
- 59515 (Cesarean delivery only; including postpartum care)

Refer to the maximum allowable fee schedule for current reimbursement rates.

Non-elective Cesarean Sections

Providers are required to use the modifier U1 (non-elective cesarean section) with the three procedure codes listed above for non-elective cesarean sections. The following are examples of non-elective cesarean sections, when the use of the U1 modifier is appropriate:

- The mother has already had a cesarean section in a previous pregnancy.
- The mother has a serious medical condition that requires emergency treatment.
- The mother has an infection that may be transmitted to the baby, such as herpes or HIV (Human Immunodeficiency Virus).
- The mother is delivering twins, triplets, or more.
- The baby is in a breech or transverse position.
- The baby is showing signs of severe fetal distress requiring immediate delivery.

Non-elective cesarean sections will receive current reimbursement rates when billed with the U1 modifier.

Cesarean Section Procedure Codes That Do Not Require a Modifier

The following cesarean procedure codes do not require a modifier and will receive current reimbursement rates:

- 59618 (Routine obstetric care including antepartum care, vaginal delivery [with or without episiotomy, and/or forceps] and postpartum care, after previous cesarean delivery)
- 59620 (Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery)
- 59622 (Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care)

Topic #1258

Complications During Delivery

If a Medicaid-enrolled nurse practitioner with obstetric specialty or nurse midwife encounters a situation during delivery that requires the assistance of a physician, the physician who performed the delivery is required to submit a claim for the delivery.

The nurse practitioner with obstetric specialty or nurse midwife may be reimbursed for their service by submitting a paper 1500 Health Insurance Claim Form ((02/12)) using the CPT (Current Procedural Terminology) procedure code 99499 (Unlisted evaluation and management services) in addition to any antepartum and postpartum care provided. Documentation on the medical necessity of the services provided must be submitted with the claim. Reimbursement is determined by the ForwardHealth medical consultant.

Topic #1257

Complications of Pregnancy

Complications of pregnancy or delivery, such as excessive bleeding, pregnancy-induced hypertension, toxemia, hyperemesis, premature (not-artificial) rupture of membranes, and other complications during the postpartum period may all be reported and reimbursed separately from obstetrical care. The nature of these complications should be fully documented in the member's medical record.

Topic #1256

Emergency Deliveries

Nurse midwives who perform emergency deliveries outside either an inpatient hospital setting or the patient's home are covered if documentation (i.e., history, physical examination, or summaries) attached to the paper claim supports the procedure's urgent or emergent nature. Nurse midwives should call Provider Services for more information about deliveries performed outside an inpatient hospital setting or a member's home. Claims for these situations are special handled.

Topic #1254

Global Obstetric Care

Providers may submit claims using global obstetric codes. Providers choosing to submit claims for global obstetric care are

required to perform all of the following:

- A minimum of six antepartum visits.
- Vaginal or cesarean delivery.
- The post-delivery hospital visit and a minimum of one postpartum office visit.

When submitting claims for total obstetric care, providers should use the single most appropriate CPT (Current Procedural Terminology) obstetric procedure code and a single charge for the service. Use the date of delivery as the DOS (date of service).

All services must be performed to receive reimbursement for global obstetric care. Providers are required to provide all six (or more) antepartum visits, delivery, and the postpartum office visit in order to receive reimbursement for global obstetric care. If fewer than six antepartum visits have been performed, the provider performing the delivery may submit a claim using the appropriate delivery procedure code and, as appropriate, antepartum and postpartum visit procedure codes.

If the required postpartum office visit does not occur following claims submission for the global delivery, the provider is required to adjust the claim to reflect antepartum care and delivery if there is no documentation of a postpartum visit in the member's medical record.

Group Claims Submission for Global Obstetric Care

When several obstetric providers in the same clinic or medical/surgical group practice perform the delivery and provide antepartum and postpartum care to the same member during the pregnancy, the clinic may choose to submit a claim using a single procedure code for the service. The provider should indicate the group billing number and identify the primary obstetric provider as the rendering provider in this situation.

Topic #1253

Health Professional Shortage Area-Enhanced Reimbursement

Many obstetric procedure codes are eligible for the HPSA (Health Professional Shortage Area)-enhanced reimbursement.

Topic #1252

Home Deliveries

Wisconsin Medicaid allows nurse midwives to perform maternity care and delivery in a member's home (POS (place of service) code "12"). Allowable maternity care and delivery procedure codes have been identified by Wisconsin Medicaid.

Topic #1255

Member Enrollment

Services Provided Before the Member Was Enrolled in BadgerCare Plus

Obstetric payments apply only to services provided while the person is eligible as a member. Services provided prior to BadgerCare Plus enrollment are not included in the number of antepartum visits, the delivery, or postpartum care.

Fee-for-Service Member Subsequently Enrolled in a BadgerCare Plus or Medicaid HMO or SSI HMO

Wisconsin Medicaid will reimburse the equivalent of one global obstetric fee per member, per delivery, per single provider or provider group, whether the provider receives the reimbursement through BadgerCare Plus fee-for-service or through a BadgerCare Plus or Medicaid HMO or SSI (Supplemental Security Income) HMO.

A member who is initially eligible for BadgerCare Plus fee-for-service may enroll in a Medicaid HMO during her pregnancy and receive care from the same provider or clinic. In this case, the provider may be paid a global fee by the HMO after the provider receives fee-for-service payment for the antepartum care. If this is the case, the provider is required to submit an adjustment request to have the fee-for-service payment recouped.

If the provider does not submit an adjustment request in this situation, Wisconsin Medicaid will recoup the fee-for-service payment(s) through audit. If the member receives less than global obstetric care while enrolled in the BadgerCare Plus or Medicaid HMO, Wisconsin Medicaid reimburses her provider no more than the global maximum allowable fee or the sum of the individual components for services. Wisconsin Medicaid will, on audit, recoup any amount paid under fee-for-service that is more than the global fee or the combined maximum allowable fee for the services if billed separately.

Topic #2615

Newborn Reporting

Obstetric care providers are required to report babies born to BadgerCare Plus members by following the newborn reporting procedures.

Topic #1270

Newborn Screenings

All providers are required to offer to test newborns for certain congenital and metabolic disorders, per Wis. Stat. § 253.13. These tests require a prepaid filter paper card purchased from the State Laboratory of Hygiene. Wisconsin Medicaid reimburses providers for purchasing the prepaid filter paper cards for newborn screenings performed outside a hospital setting. Medicaid reimbursement for the filter paper cards includes the laboratory handling fee. Reimbursement is limited to one prepaid filter paper card per newborn. When a baby is delivered in the home or birthing center, providers are required to use HCPCS (Healthcare Common Procedure Coding System) code S3620 (Newborn metabolic screening panel, includes test kit, postage and the laboratory tests specified by the state for inclusion in this panel [e.g. galactose; hemoglobin, electrophoresis; hydroxyprogesterone, 17-D; PKU (phenylalanine); and thyroxine, total]) to report the screening panel service.

Newborn Hearing Screening

Evoked otoacoustic emissions hearing screens for newborns are included in the E&M (evaluation and management) of the newborn and are not separately reimbursable. Wisconsin Medicaid separately reimburses CPT code 92586 (Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited) following a newborn's failed hearing screening, if medically necessary.

Critical Congenital Heart Disease Screening

Screening for critical congenital heart disease by pulse oximetry is included in the initial E&M of the newborn and is not separately reimbursable.

Topic #1250

Separately Reimbursable Pregnancy-Related Services

Services that may be reimbursed separately from the global or component obstetrical services may include:

- Administration of Rh immune globulin.
- Amniocentesis, chorionic villous sampling, and cordocentesis.
- Epidural anesthesia.
- External cephalic version.
- Fetal biophysical profiles.
- Fetal blood scalp sampling.
- Fetal contraction stress and non-stress tests.
- Harvesting and storage of cord blood.
- Insertion of cervical dilator.
- Laboratory tests, excluding dipstick urinalysis.
- Obstetrical ultrasound and fetal echocardiography.
- Sterilization.
- Surgical complications of pregnancy (e.g., incompetent cervix, hernia repair, ovarian cyst, Bartholin cyst, ruptured uterus, or appendicitis).

Topic #1248

Unrelated Conditions

Any E&M (evaluation and management) services performed that are related to the pregnancy are included in reimbursement for obstetrical care. However, conditions unrelated to the pregnancy may be separately reimbursed by Wisconsin Medicaid, including:

- Chronic hypertension.
- Diabetes.
- Management of cardiac, neurological, or pulmonary problems.
- Other conditions (e.g., urinary tract infections) with a diagnosis other than complication of pregnancy.

Topic #1247

Unusual Pregnancies

Providers treating members whose pregnancies require more than the typical number of antepartum or postpartum visits or result in complications during delivery may seek additional reimbursement by submitting an Adjustment/Reconsideration Request (F-13046 (07/12)) form for the allowed claim. A copy of the medical record and/or delivery report specifying the medical reasons for the extraordinary number of antepartum or postpartum visits must be attached to the claim. Wisconsin Medicaid will review the materials and determine the appropriate level of reimbursement.

Managed Care

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Archive Date:03/02/2020

Managed Care:Claims

Topic #384

Appeals to BadgerCare Plus and Medicaid SSI HMOs

BadgerCare Plus and Medicaid SSI managed care contracted and non-contracted providers are required to first file an appeal directly with the BadgerCare Plus or Medicaid SSI HMO after the initial payment denial or reduction. Providers should refer to their signed contract with the HMO or the HMO's website for specific filing timelines and responsibilities (for example, PA (prior authorization), claim filing timelines, and coordination of benefits requirements) pertaining to filing a claim reconsideration and/or filing a formal appeal. The provider's signed contract with the HMO may dictate the final decision. Filing a claim reconsideration is not the same as filing a formal appeal.

Appeal documents must reach the HMO within the time frame established by the HMO. Special care should be taken to ensure the documents reach the HMO by the timely filing deadline by allowing enough time for U.S. Postal Service mail handling or by using a verifiable delivery method (for example, fax, certified mail, or secure email).

The BadgerCare Plus or Medicaid SSI HMO has 45 calendar days to respond in writing to an appeal. The BadgerCare Plus or Medicaid SSI HMO decides whether or not to pay the claim and sends a letter stating this decision. If the BadgerCare Plus or Medicaid SSI HMO does not respond in writing within 45 calendar days or the provider is dissatisfied with the BadgerCare Plus or Medicaid SSI HMO's response, the provider may send a written appeal to ForwardHealth within 60 calendar days from the end of the 45 calendar day timeline or the date of the HMO response.

Topic #385

Appeals to ForwardHealth

BadgerCare Plus or Wisconsin Medicaid **will not review** appeals that were not first made to the BadgerCare Plus or Medicaid SSI HMO. If a provider sends an appeal directly to BadgerCare Plus or Wisconsin Medicaid without first filing it with the BadgerCare Plus or Medicaid SSI HMO, the appeal will be returned to the provider.

The provider has 60 calendar days to file an appeal with BadgerCare Plus or Wisconsin Medicaid after the BadgerCare Plus or Medicaid SSI HMO either does not respond in writing within 45 calendar days or if the provider is dissatisfied with the BadgerCare Plus or Medicaid SSI HMO response.

Appeals will only be reviewed for enrollees who were eligible for and who were enrolled in a BadgerCare Plus or Medicaid SSI HMO on the DOS (date of service) in question.

Once all pertinent information is received, ForwardHealth has 45 calendar days to make a final decision. The provider and the BadgerCare Plus or Medicaid SSI HMO will be notified by ForwardHealth in writing of the final decision. If the decision is in the provider's favor, the BadgerCare Plus or Medicaid SSI HMO is required to pay the provider within 45 calendar days of the final decision. The decision is final, and all parties are required to abide by the decision.

Providers are required to submit an appeal with legible copies of all of the following documentation using either the Managed Care Program Provider Appeal (F-12022 (02/2020)) form or their own appeal letter:

- The original claim submitted to the HMO and all corrected claims submitted to the HMO
- All of the HMO's payment denial remittances showing the dates of denial and reason codes with descriptions of the exact reasons for the claim denial

- The provider's written appeal to the HMO
- The HMO's response to the appeal
- Relevant medical documentation for appeals regarding coding issues or emergency determination that supports the appeal
- Any contract language that supports the provider's appeal with the exact language that supports overturning the payment denial indicated
- Any other documentation that supports the appeal (for example, commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort)

Only relevant documentation should be included. Large documents should be submitted on a CD.

Appeals may be faxed to ForwardHealth at 608-224-6318 or mailed to the following address:

BadgerCare Plus and Medicaid SSI
Managed Care Unit—Provider Appeal
PO Box 6470
Madison WI 53716-0470

A decision to uphold the HMO's original payment denial or to overturn the denial will be made based on the documentation submitted for review. Failure to submit the required documentation or submitting incomplete or insufficient documentation may lead to an upholding of the original denial. The decision to overturn an HMO's denial must be clearly supported by the documentation.

Providers must notify ForwardHealth if the HMO subsequently overturns their original denial and reprocesses and pays the claim for which they have submitted an appeal. Notifications should be faxed to ForwardHealth at 608-224-6318. This documentation will be added to the original appeal documentation to complete the record.

Contact ForwardHealth Provider Services (Managed Care Unit) at 800-760-0001, option 1, to check the status of an appeal submitted to ForwardHealth.

Topic #386

Claims Submission

BadgerCare Plus and Medicaid SSI HMOs have requirements for timely filing of claims, and providers are required to follow the BadgerCare Plus and Medicaid SSI HMO claims submission guidelines for each organization. Providers should contact the enrollee's BadgerCare Plus or Medicaid SSI HMO for organization-specific submission deadlines.

Topic #387

Extraordinary Claims

Extraordinary claims are BadgerCare Plus or Medicaid claims for a BadgerCare Plus or Medicaid SSI HMO enrollee that have been denied by a BadgerCare Plus or Medicaid 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 a BadgerCare Plus or Medicaid SSI HMO at the time they were admitted to an inpatient hospital, but then they enrolled in a BadgerCare Plus or Medicaid 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 Item Number 18 of the paper 1500 Health Insurance Claim Form ((02/12)).

- The claims are for orthodontia/prosthodontia services that began before BadgerCare Plus or Medicaid SSI HMO coverage. The provider must include a record with the claim indicating when the bands were placed.

Submitting Extraordinary Claims

When submitting an extraordinary claim, providers must 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
- A copy of the Explanation of Medical Benefits form as applicable

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 or Medicaid SSI HMO. Before submitting claims to BadgerCare Plus and Medicaid SSI HMOs, providers are required to submit claims to other health insurance sources. Providers should contact the enrollee's BadgerCare Plus or Medicaid SSI HMO for more information about billing other health insurance sources.

Topic #389

Provider Appeals

When a BadgerCare Plus or Medicaid SSI HMO denies a provider's claim, the BadgerCare Plus or Medicaid SSI HMO is required to send the provider a notice informing them of the right to file an appeal.

A BadgerCare Plus or Medicaid SSI HMO network or non-network provider may file an appeal to the BadgerCare Plus or Medicaid SSI HMO when:

- A claim submitted to the BadgerCare Plus or Medicaid SSI HMO is denied payment.
- The full amount of a submitted claim is not paid.

Providers are required to file an appeal with the BadgerCare Plus or Medicaid SSI HMO **before** filing an appeal with ForwardHealth.

Covered and Noncovered Services

Topic #16197

Care4Kids Program Benefit Package

Covered Services

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

Noncovered Services

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

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

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

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

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

Topic #390

Covered Services

HMOs

HMOs 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 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 or Medicaid SSI HMOs but are provided to enrollees on a fee-for-service basis provided the service is covered for the member and is medically necessary:

- Behavioral treatment
- County-based mental health programs, including CRS (Community Recovery Services), CSP (Community Support Program) benefits, and crisis intervention services
- Environmental lead investigation services provided through local health departments
- CCC (child care coordination) services provided through county-based programs
- Pharmacy services and diabetic supplies
- PNCC (prenatal care coordination) services
- Provider-administered drugs

  *Note:*The Provider-Administered Drugs Carve-Out Procedure Codes table indicates the status of procedure codes considered under the provider-administered drugs carve-out policy.

- SBS (school-based services)
- Targeted case management services
- NEMT (non-emergency medical transportation) services
- DOT (directly observed therapy) and monitoring for TB (tuberculosis)-Only Services

Providers that render these services to an SSI HMO member are required to submit claims directly to ForwardHealth on a fee-for-service basis.

Note: Members enrolled in an SSI HMO are not eligible for targeted case management services.

Enrollment

Topic #392

Disenrollment and Exemptions

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

The contracts between the Wisconsin DHS (Department of Health Services) and the HMOs 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 or Medicaid SSI HMO. Enrollees also have the right to file a grievance when the HMO or SSI HMO refuses to provide a service. All HMOs and SSI HMOs are required to have written policies and procedures in place to handle enrollee grievances. Enrollees should be encouraged to work with their HMO's or SSI HMO's customer service department to resolve problems first.

If enrollees are unable to resolve problems by talking to their HMO or SSI HMO, or if they would prefer to speak with someone outside their HMO or SSI HMO, they should contact the Enrollment Specialist or the Ombudsman Program.

The contracts between the Wisconsin 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 BadgerCare Plus are eligible for enrollment in a BadgerCare Plus HMO.

An individual who receives Tuberculosis-Related Medicaid, SeniorCare, or Wisconsin Well Woman Medicaid cannot be enrolled in a BadgerCare Plus HMO.

Information about a member's HMO enrollment status and other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) 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 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.

Topic #394

Enrollment Periods

BadgerCare Plus HMOs

Eligible enrollees are sent enrollment packets that explain the BadgerCare Plus HMOs and the enrollment process and provide contact information. Once enrolled in a BadgerCare Plus HMO, members 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, they will be disenrolled from the HMO.

SSI HMOs

Eligible enrollees are sent enrollment packets that explain the Medicaid SSI HMO enrollment process and provide contact information. Once enrolled in an SSI HMO, members may change their HMO assignment within the first 90 days of enrollment in an HMO (whether they chose the HMO or were auto-assigned).

Topic #395

Enrollment Specialist

The Enrollment Specialist provides objective enrollment, education, outreach, and advocacy services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees. The Enrollment Specialist is a knowledgeable single point of contact for enrollees, solely dedicated to managed care issues. The Enrollment Specialist is not affiliated with any health care agency.

The Enrollment Specialist provides the following services to HMO and SSI HMO enrollees:

- Education regarding the correct use of HMO and SSI HMO benefits
- Telephone and face-to-face support
- Assistance with enrollment, disenrollment, and exemption procedures

Topic #398

Member Enrollment

HMOs

BadgerCare Plus HMO enrollment is either mandatory or voluntary based on ZIP code-defined enrollment areas as follows:

- Mandatory enrollment — Enrollment is mandatory for eligible members who reside in ZIP code areas served by two or more BadgerCare Plus HMOs. Some members may meet criteria for exemption from BadgerCare Plus HMO enrollment.
- Voluntary enrollment — Enrollment is voluntary for members who reside in ZIP code areas served by only one

BadgerCare Plus HMO.

Members living in areas where enrollment is mandatory are encouraged to choose their BadgerCare Plus HMO. Automatic assignment to a BadgerCare Plus HMO occurs if the member does not choose a BadgerCare Plus HMO. In general, all members of a member's immediate family eligible for enrollment must choose the same HMO.

Members in voluntary enrollment areas can choose whether or not to enroll in a BadgerCare Plus HMO. There is no automatic assignment for members who live within ZIP codes where enrollment is voluntary.

SSI HMOs

Medicaid SSI HMO enrollment is either mandatory or voluntary as follows:

- Mandatory enrollment — Most SSI and SSI-related members are required to enroll in an SSI HMO. A member may choose the SSI HMO in which he or she wishes to enroll.
- Voluntary enrollment — Some SSI and SSI-related members may choose to enroll in an SSI HMO on a voluntary basis.

Topic #396

Ombudsman Program

The Ombudsmen, or Ombuds, are resources for enrollees who have questions or concerns about their BadgerCare Plus HMO or Medicaid SSI HMO. Ombuds provide advocacy and assistance to help enrollees understand their rights and responsibilities in the grievance and appeal process.

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 and Medicaid SSI HMO enrollee rights regarding the confidentiality of health care records. ForwardHealth has specific standards regarding the release of an HMO or SSI HMO enrollee's billing information or medical claim records.

Managed Care Information

Topic #401

BadgerCare Plus HMO Program

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

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

Topic #16177

Care4Kids Program Overview

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

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

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

Program Administration

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

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

Member Enrollment Verification

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

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

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

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

Contact Information

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

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

Topic #405

Managed Care

Managed Care refers to the BadgerCare Plus HMO program, the Medicaid SSI HMO program, and the following MLTC (managed long-term care) programs available: Family Care, Family Care Partnership, and PACE (Program of All-Inclusive Care for the Elderly).

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 Wisconsin DHS (Department of Health Services) and the BadgerCare Plus HMO or Medicaid SSI HMO takes precedence over other ForwardHealth provider publications. Information contained in ForwardHealth publications is used by DHS to resolve disputes regarding covered benefits that cannot be handled internally by HMOs 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 #403

Managed Long-Term Care Programs

Wisconsin Medicaid has several MLTC (managed long-term 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, PACE (Program of All-Inclusive Care for the Elderly), and the Family Care Partnership Program. Additional information about these MLTC programs may be obtained from the Managed Care Organization area of the ForwardHealth Portal.

Topic #404

SSI HMO Program

Medicaid SSI HMOs provide the same benefits as Medicaid fee-for-service (e.g., medical, dental [in certain counties only], mental health/substance abuse, and vision) at no cost to their members through a care management model. Medicaid SSI members and SSI-related Medicaid members 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

Certain eligible SSI members and SSI-related Medicaid adult members are required to enroll in an SSI HMO. The following groups are excluded from the requirement to enroll in an SSI HMO:

- Members under 19 years of age
- Members of a federally recognized tribe
- Dual eligible members
- MAPP (Medicaid Purchase Plan) eligible members
- Members enrolled in a LTC (long-term care) MCO (managed care organization) or waiver program

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 90 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 ForwardHealth. The PA must be honored for 90 days or until the month following the HMO's completion of the assessment and care plan, whichever comes later.

To assure payment, non-contracted providers should contact the SSI HMO to confirm claim submission and reimbursement processes. If an SSI HMO is not honoring a PA that is currently approved by ForwardHealth, the provider should first contact the HMO. If the provider is not able to resolve their issue with the HMO, the provider should contact ForwardHealth Provider Services.

For new authorizations during the member's first 90 days of enrollment, the provider is required to follow the SSI HMO's PA process. SSI HMOs may use PA guidelines that differ from fee-for-service guidelines; however, these guidelines may not result in less coverage than fee-for-service.

Care Management

SSI HMO health plans employ a care management model to ensure high-quality care to members. The care management model provides each enrollee with the following:

- An initial health assessment
- A comprehensive care plan
- Assistance in choosing providers and identifying a primary care provider
- Assistance in accessing social and community services
- Information about health education programs, treatment options, and follow-up procedures
- Advocates on staff to assist members in choosing providers and accessing needed care

ForwardHealth requires all SSI HMO health plans to have dedicated care managers to assist providers in meeting the medical care needs of members. SSI HMOs, through their care management teams, will serve as single points of contact for providers who need assistance addressing the health care needs of members, especially those who have multiple points of contact within the health care system.

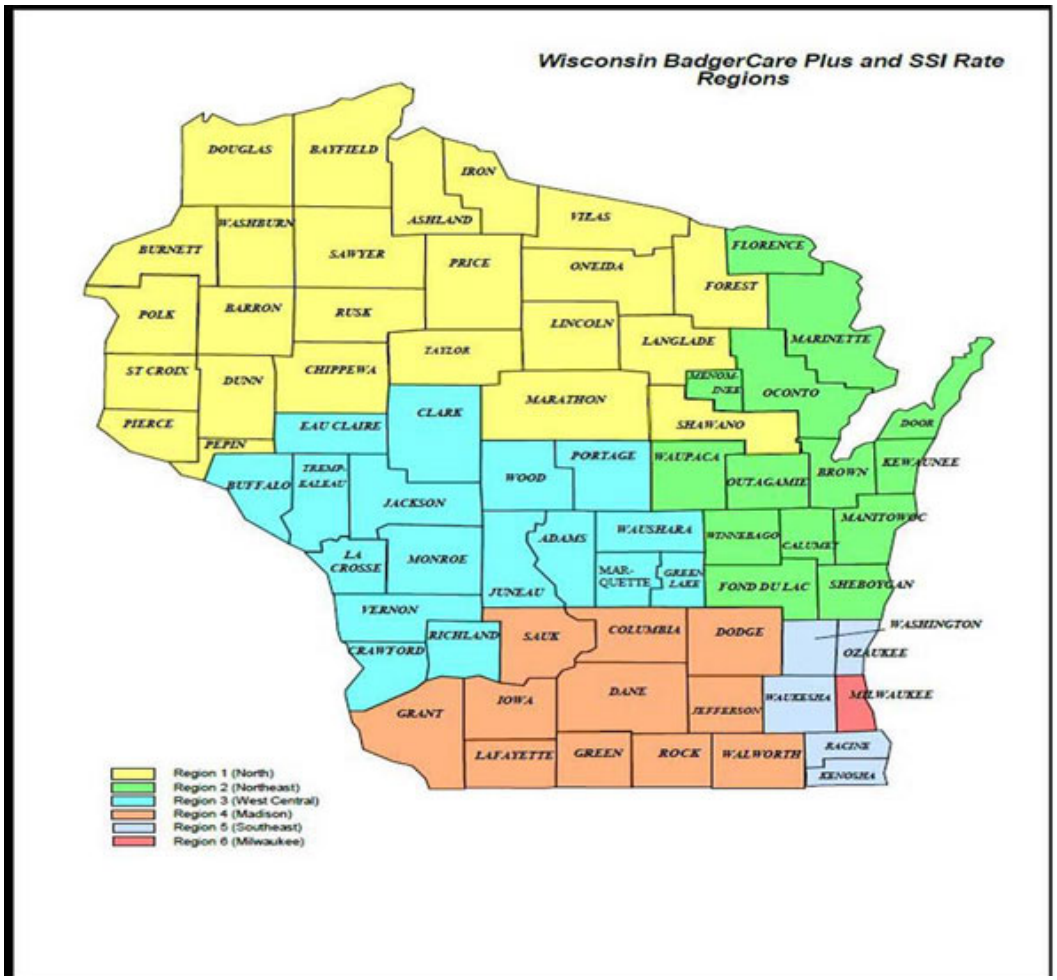
The SSI HMO care management teams will be responsible, when it is deemed appropriate, for notifying primary care providers of members' emergency room visits, hospital discharges, and other major medical events, as well as sharing patient-specific care management plans with appropriate providers to reduce hospital admissions and readmission, to reduce appointment no-shows, and to improve compliance with health care recommendations such as medication regimens.

Topic #20697

SSI Rate Regions

The map below shows the Wisconsin BadgerCare Plus and SSI (Supplemental Security Income) Rate Regions for the SSI HMO Program.

SSI Rate Regions


Wisconsin BadgerCare Plus and SSI Rate Regions
DOUGLAS
BAYFIELD
IRON
ASHLAND
VILAS
WASHBURN
BURNETT
SAWYER
PRICE
ONEIDA
FLORENCE
FOREST
POLK
BARRON
RUSK
LINCOLN
LANGLADE
MARINETTE
ST CROIX
DUNN
CHIPPEWA
TAYLOR
MENOM-INEE
OCONTO
PIERCE
EAU CLAIRE
CLARK
MARATHON
SHAWANO
DOOR
PEPIN
BUFFALO
TREMP-EALEAU
JACKSON
WOOD
PORTAGE
WAUPACA
OUTAGAMIE
BROWN
KEWAUNEE
ADAMS
WAUSHARA
WINNEBAGO
CALUMET
MANITOWOC
LA CROSSE
MONROE
JUNEAU
MAR-QUETTE
GREEN LAKE
FOND DU LAC
SHEBOYGAN
VERNON
RICHLAND
SAUK
COLUMBIA
DODGE
WASHINGTON
CRAWFORD
OZAUKEE
GRANT
IOWA
DANE
JEFFERSON
WAUKESHA
MILWAUKEE
LAFAYETTE
GREEN
ROCK
WALWORTH
RACINE
KENOSHA
Region 1 (North)
Region 2 (Northeast)
Region 3 (West Central)
Region 4 (Madison)
Region 5 (Southeast)
Region 6 (Milwaukee)

Prior Authorization

Topic #400

Prior Authorization Procedures

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

Provider Information

Topic #406

Copayments

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

When services are provided through fee-for-service or to members enrolled in a BadgerCare Plus HMO, copayments will apply, except when the member or the service is exempt from the copayment requirement.

Topic #407

Emergencies

Non-network providers may provide services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees in an emergency without authorization or in urgent situations when authorized by the HMO or SSI HMO. The contract between the Wisconsin 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 C.F.R. § 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 or Medicaid SSI HMO are referred to as non-network providers. (HMO and SSI HMO network providers agree to payment amounts and billing procedures in a contract with the HMO or SSI HMO.) Non-network providers are required to direct enrollees to HMO or SSI HMO network providers except in the following situations:

- When a non-network provider is treating an HMO or SSI HMO enrollee for an emergency medical condition as defined in the contract between the Wisconsin 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 and Medicaid SSI HMOs may cover medically necessary care provided to enrollees when they travel outside the HMO's or SSI HMO's service area. The HMO or SSI HMO is required to authorize the services before the services are provided, except in cases of emergency. If the HMO or SSI HMO does not authorize the services, the enrollee may be held responsible for the cost of those services.

Topic #410

Provider Participation

Providers interested in participating in a BadgerCare Plus HMO or Medicaid SSI HMO or changing HMO or SSI HMO network affiliations should contact the HMO or SSI HMO for more information. Conditions and terms of participation in an HMO or SSI HMO are pursuant to specific contract agreements between HMOs or SSI HMOs and providers. An HMO or SSI HMO has the right to choose whether or not to contract with any provider but must provide access to Medicaid-covered, medically-necessary services under the scope of their contract for enrolled members. Each HMO may have policies and procedures specific to their provider credentialing and contracting process that providers are required to meet prior to becoming an in-network provider for that HMO.

Topic #411

Referrals

Non-network providers may at times provide services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees on a referral basis. Non-network providers are always required to contact the enrollee's HMO or SSI HMO. Before services are provided, the non-network provider and the HMO or SSI HMO should discuss and agree upon billing procedures and fees for all referrals. Non-network providers and HMOs or SSI HMOs should document the details of any referral in writing before services are provided.

Billing procedures for out-of-plan referrals may vary depending on the HMO or SSI HMO. For specific billing instructions, non-network providers should always contact the enrollee's HMO or SSI HMO.

Topic #412

Services Not Provided by HMOs or SSI HMOs

If an enrollee's BadgerCare Plus HMO or Medicaid SSI 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

5

Archive Date:03/02/2020

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 Wisconsin 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 Wis. Stats. § 51.44, and the regulations are found in Wis. Admin. Code ch. DHS 90.

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 their 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 #225

BadgerCare Plus

Populations Eligible for BadgerCare Plus

The following populations are eligible for BadgerCare Plus:

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

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

Premiums

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

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

Topic #16677

BadgerCare Plus Benefit Plan Changes

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

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

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

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

Topic #785

BadgerCare Plus Prenatal Program

As a result of 2005 Wisconsin Act 25, 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 Plus Prenatal Program 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 income maintenance or tribal 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., claim 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 #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 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 income maintenance or tribal agency.

Topic #226

Family Planning Only Services

Family Planning Only Services is a limited benefit program that provides routine contraceptive management or related services to low-income individuals who are of childbearing/reproductive age (typically 15 years of age or older) and who are otherwise not eligible for Wisconsin Medicaid or BadgerCare Plus. Members receiving Family Planning Only Services must be receiving routine contraceptive management or related services.

Note: Members who meet the enrollment criteria may receive routine contraceptive management or related services **immediately** by temporarily enrolling in Family Planning Only Services through EE (Express Enrollment).

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 Wisconsin Medicaid and BadgerCare Plus (e.g., mammograms and hysterectomies). If a medical condition, other than an STD (sexually transmitted disease), is discovered during routine contraceptive management or 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 management or 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 management or 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 coverage options and provide referrals for care not covered by Family Planning Only Services.

Topic #4757

ForwardHealth and ForwardHealth interChange

ForwardHealth brings together many Wisconsin 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

- ADAP (Wisconsin AIDS Drug Assistance Program)
- 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, DXC Technology.

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 Prenatal Program
- EE (Express Enrollment) for Children
- EE for Pregnant Women
- Family Planning Only Services, including EE for individuals applying 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)
- Tuberculosis-Related Medicaid

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 the BadgerCare Plus Prenatal Program, Family Planning Only Services, EE for Children, EE for Pregnant Women, or Tuberculosis-Related Medicaid 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 Tuberculosis-Related Medicaid.

Providers are strongly encouraged to verify dates of enrollment and other coverage information using Wisconsin's EVS (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 Wis. Stat. ch. 49.

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 they are 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:

- Income maintenance 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 #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 income maintenance 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 Beneficiary)

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 income maintenance 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 income maintenance 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 #18777

Real-Time Eligibility Determinations

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

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

Eligibility Verification

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

On rare occasions, it may take up to 48 hours for eligibility information to be available through interChange. In such instances, if a

member presents a valid temporary ID card, **the provider is still required to provide services**, even if eligibility cannot be verified through EVS.

Sample Temporary Identification Card for Badger Care Plus

To the Provider

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

NOTE:

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

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR BADGERCARE PLUS

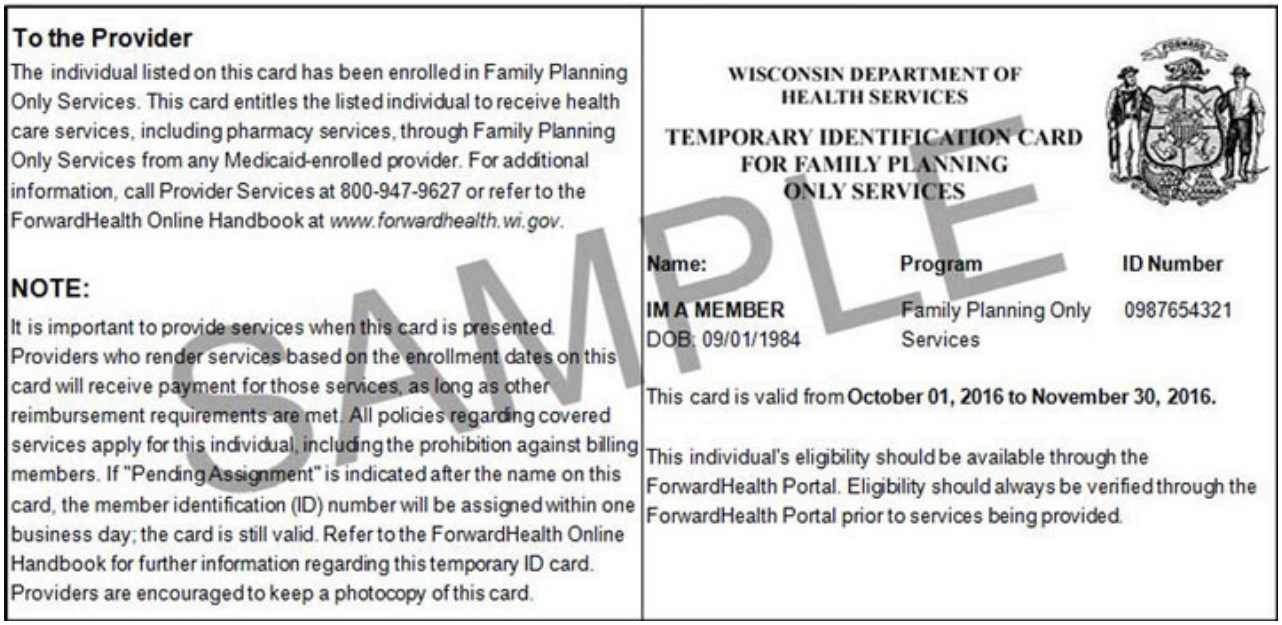
Name:	Program	ID Number
IM A MEMBER DOB: 09/01/1984	BadgerCare Plus	0987654321

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

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

SAMPLE

Sample Temporary Identification Card for Family Planning Only Services



To the Provider

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

NOTE:

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

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR FAMILY PLANNING ONLY SERVICES

SAMPLE

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

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

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

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 income maintenance 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 Medicaid

Tuberculosis-Related Medicaid 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.

Enrollment Responsibilities

Topic #241

General Information

Members have certain responsibilities per Wis. Admin. Code § DHS 104.02 and the ForwardHealth Enrollment and Benefits (P-00079 (07/14)) 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 Wis. Admin. Code § DHS 104.02(2), a member should inform providers that they are 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 their 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, Medicaid, or ADAP (Wisconsin AIDS Drug Assistance Program) 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 Wis. Admin. Code § HA 3.03, 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, ADAP, or Wisconsin Medicaid was denied.
- Application for BadgerCare Plus, ADAP, 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

Claim Denial Due to Termination of BadgerCare Plus or Wisconsin Medicaid Enrollment

If a claim is denied due to termination of BadgerCare Plus or Wisconsin Medicaid 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.

Claim Denial Due to Termination of ADAP Enrollment

If a claim is denied due to termination of ADAP 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
ADAP Claims and Adjustments
PO Box 8758
Madison WI 53708

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 ADAP Claims and Adjustments.

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 Wis. Admin. Code ch. DHS 103.

Topic #250

Notification of Discontinued Benefits

When 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, 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 #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 their 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 they do 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, they may call Member Services to request a new one.

If a member lost their 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 #1435

Types of Identification Cards

ForwardHealth members receive an identification card upon initial eligibility determination. Identification cards may be presented in different formats (e.g., white plastic cards, paper cards, or paper printouts), depending on the program and the method used to enroll (i.e., paper application or online application). Members who are temporarily enrolled in BadgerCare Plus or Family Planning Only Services receive temporary identification cards.

Misuse and Abuse of Benefits

Topic #271

Examples of Member Abuse or Misuse

Examples of member abuse or misuse are included in Wis. Admin. Code § DHS 104.02(5).

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 Wis. Admin. Code § DHS 104.02.

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 Wis. Admin. Code § DHS 104.02. 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 HMOs 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.

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 their medical services. Border-status providers follow the same policies as Wisconsin providers.

Topic #552

Newborn Reporting

Hospitals, physicians, nurse practitioners, nurse midwives, licensed 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, nurse midwives, and licensed 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
- Newborn weight*
- Gestational age*
- Mother's full name
- Mother's member ID number
- Mother's full address
- Provider representative signature
- Date the report was completed

*Required for babies born in Milwaukee, Waukesha, Washington, Ozaukee, Kenosha, and Racine counties.

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, rather than a generic "Girl," "Boy," or "Baby." The first name is important in order to prevent assigning multiple ID numbers to the same baby and to ensure that the name is included on the ForwardHealth ID card. Since the baby's eligibility is backdated to the date of birth, delaying the submission of the report for a short time to include all information

will not affect payment of services.

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 them 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 income maintenance or tribal 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 them to the income maintenance 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-01162 (02/09)) form for clients to take to the income maintenance 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.

Note: "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.

Pregnant women detained by legal process who qualify for the BadgerCare Plus Prenatal Program and state prison inmates who qualify for Wisconsin Medicaid or BadgerCare Plus during inpatient hospital stays may receive certain benefits. Additionally, inmates of county jails admitted to a hospital for inpatient services who are expected to remain in the hospital for 24 hours or more will be eligible for PE (presumptive eligibility) determinations for BadgerCare Plus by qualified hospitals. Refer to the Presumptive Eligibility chapter of either the Inpatient or Outpatient Hospital service area for more information on the PE determination process.

The DOC (Department of Corrections) oversees health care-related needs for individuals detained by legal process who do not qualify for the BadgerCare Plus Prenatal Program or for state prison inmates who do not qualify for Wisconsin Medicaid or BadgerCare Plus during an inpatient hospital stay.

Topic #16657

State Prison Inmates May Qualify for BadgerCare Plus or Wisconsin Medicaid During Inpatient Hospital Stays

As a result of 2013 Wisconsin Act 20, state prison inmates may qualify for BadgerCare Plus or Wisconsin Medicaid during inpatient hospital stays.

Eligibility

Only inmates of a state prison, not a county jail, are eligible to receive benefits. To qualify for BadgerCare Plus or Wisconsin Medicaid, state prison inmates must meet all applicable eligibility criteria. The DOC coordinates and reimburses inpatient hospital services for inmates who do not qualify for BadgerCare Plus or Wisconsin Medicaid.

Inmates are eligible for BadgerCare Plus or Wisconsin Medicaid for the duration of their hospital stay. Eligibility begins on their date of admission and ends on their date of discharge.

Inmates are not eligible for outpatient hospital services, including observations, under BadgerCare Plus and Wisconsin Medicaid. Inmates may only be eligible for ER (emergency room) services if they are admitted to the hospital directly from the ER and are counted in the midnight census; otherwise, ER services are considered outpatient services. Outpatient hospital services approved by the DOC are reimbursed by the DOC.

Inmates are not presumptively eligible. Retroactive eligibility will only apply to dates of admission on and after April 1, 2014.

Enrollment

The DOC coordinates the submission of enrollment applications on behalf of inmates.

Covered Services

The only services allowable by BadgerCare Plus or Wisconsin Medicaid for inmates are inpatient hospital services and professional services provided during the inpatient hospital stay that are covered under BadgerCare Plus and Wisconsin Medicaid. Providers with questions regarding services covered by BadgerCare Plus and Wisconsin Medicaid may refer to the applicable service area or contact Provider Services.

Fee-for-Service

Inmates receive services on a fee-for-service basis; they are not enrolled in HMOs.

Prior Authorization

The DOC will assist inpatient hospital providers with their submission of PA (prior authorization) requests for any services requiring PA. If PA is denied, the DOC is responsible for reimbursement of the services.

Enrollment Verification

Inmates are only enrolled for the duration of their hospital stay. Providers should always verify an inmate's enrollment in BadgerCare Plus or Wisconsin Medicaid before submitting a claim.

Claim Submission

When submitting a claim for an inmate's inpatient hospital stay, providers should follow the current claim submission procedures for each applicable service area.

Reimbursement

Acute care hospitals that provide services to inmates are reimbursed at a percentage of their usual and customary charge.

Critical access hospitals that provide services to inmates are reimbursed according to their existing Wisconsin Medicaid reimbursement methodology.

Wisconsin Medicaid reimburses professional services related to an inmate's inpatient hospital stay (e.g., laboratory services, physician services, radiology services, or DME (durable medical equipment)) at the current maximum allowable fee.

Contact Information

Providers may contact the DOC at 608-240-5139 or 608-240-5190 with questions regarding enrollment or PA for inmate inpatient hospital stays.

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 Wis. Admin. Code § DHS 104.01(11). A Medicaid-enrolled provider is required to submit claims to ForwardHealth 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 ForwardHealth **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 (02/14)) 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

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Archive Date:03/02/2020

Prior Authorization:Advanced Imaging Services

Topic #15477

Exemption from Prior Authorization

Providers Ordering Computed Tomography and Magnetic Resonance Imaging Services

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

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

Exemption from Prior Authorization Requirements Not Available for Positron Emission Tomography

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

Process for Obtaining an Exemption from Prior Authorization Requirements

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

1. Complete a Prior Authorization Requirements Exemption Request for Computed Tomography (CT), Magnetic Resonance (MR), and Magnetic Resonance Elastography (MRE) Imaging Services (F-00787 (02/19)) and agree to its terms.
2. Submit the completed Prior Authorization Requirements Exemption Request for CT, MR, and MRE Imaging Services to the mailing or email address listed on the form. Once received, ForwardHealth will review the exemption request materials, approve or deny the request, and send a decision letter to the requesting provider within 60 days after receipt of all necessary documentation. ForwardHealth will contact the requesting provider if any additional information is required for the application.
3. If the exemption request is approved, submit a list of all individual providers who order CT, MR, and MRE scans using the requesting provider's decision support tool. Exemptions are verified using the NPI (National Provider Identifier) of the individual ordering provider; therefore, requesting providers should submit a complete list of all individual ordering providers within the requesting provider's group to ForwardHealth. Lists may be submitted via email to DHSPAExemption@wisconsin.gov.

Process for Maintaining an Exemption from Prior Authorization Requirements

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

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

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

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

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

Updating the List of Eligible Providers

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

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

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

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

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

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

Providers Rendering Advanced Imaging Services

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

Claim Submission

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

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

Topic #10678

Prior Authorization for Advanced Imaging Services

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

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

Promoting Interoperability Program

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Archive Date:03/02/2020

Promoting Interoperability Program:An Overview

Topic #16897

Certified Electronic Health Record Technology

All Eligible Professionals are required to adopt CEHRT (Certified Electronic Health Record Technology) that meets the criteria outlined by ONC (Office of the National Coordinator for Health Information Technology), regardless of the stage of Meaningful Use they are demonstrating. Eligible Professionals are required to have the following:

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

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

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

Documentation Requirements

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

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

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

- Vendor
- Product
- Product version number

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

Submission Requirements

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

Uploading Documentation

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

Emailing Documentation

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

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

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

Topic #12037

Overview of the Promoting Interoperability Program

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

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

Eligible Professionals must first register through the CMS (Centers for Medicare & Medicaid Services) R&A (Medicare and Medicaid PI Program Registration and Attestation System) system. Eligible Professionals may then apply with the Wisconsin Medicaid PI Program. All Wisconsin Medicaid PI Program applications will be submitted through the secure Provider area of the ForwardHealth Portal.

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

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

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

- First payment year: Eligible Professionals can apply for incentive payments for adopting, implementing, upgrading, demonstrating Meaningful Use of CEHRT.
- Second payment year: Eligible Professionals are required to demonstrate Meaningful Use of CEHRT during any 90-day, continuous period during the payment year.
- Third–sixth payment year: Eligible Professionals are required to demonstrate Meaningful Use of CEHRT for either a 90-day period or the full calendar year depending on the stage of Meaningful use to which they attest and the Program Year of that attestation.

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

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

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

Appeals

Topic #12137

Appeals Process

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

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

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

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

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

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

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

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

Topic #12477

Valid Reasons to Appeal

Eligible Professionals and Hospitals may only appeal to the Wisconsin Medicaid PI (Promoting Interoperability) Program for the following reasons:

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

Appealing a Payment Amount

Eligible Professionals 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 PI Program payment.

Appealing a Denied Wisconsin Medicaid Promoting Interoperability Program Application

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

Eligible Professionals 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 CMS (Centers for Medicare & 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 PI Program application. - For Eligible Professionals, provide the patient volume for the reported 90-day period on the Wisconsin Medicaid PI 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 PI Program. If the question was answered incorrectly when completing the original Wisconsin Medicaid PI 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 PI Program.	Eligible Hospitals must agree to participate in only one state's Medicaid PI Program. If the question was answered incorrectly when completing the original Wisconsin Medicaid PI Program application, provide a clarifying statement that the Eligible Hospital confirms to only participate in the Wisconsin Medicaid PI 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 PI 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 PI 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 they are hospital based.	Eligible Professionals are not eligible for the Wisconsin Medicaid PI Program if they provide 90 percent or more of their services to eligible members in an inpatient hospital or emergency department. If the question was answered incorrectly when completing the original Wisconsin Medicaid PI Program application, provide a clarifying statement that the Eligible Professional is not hospital based.
The Eligible Professional has indicated they are not waiving their right to a Medicare PI Program payment for this payment year. Eligible Professionals must select to register with either Medicare or Medicaid PI Program, but not both.	Eligible Professionals may participate in either Medicare or Medicaid PI Programs, but not both. If the question was answered incorrectly when completing the original Wisconsin Medicaid PI Program application, provide a clarifying statement that the Eligible Professional is waiving their right to a Medicare PI 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 PI Program application.
Eligible Hospital payment amount	Upload the Eligible Hospital's Medicare and Medicaid Cost Reports for the last four years.

Clinical Quality Measures

Topic #16879

Clinical Quality Measures Overview

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

Per CMS (Centers for Medicare & Medicaid Services), Eligible Professionals must report on a total of six clinical quality measures. Of the six, one must be an "outcome" measure. If no outcome measures are relevant to the provider's scope of practice, then the provider must report on one "high-priority" CQM. If no outcome or high-priority CQMs are relevant to the Eligible Professional's scope of practice, the Eligible Professional must report on any six CQMs. This requirement is new starting in Program Year 2019.

Outcome measures are those that speak to an actual clinical patient outcome rather than measuring whether a process was completed. CQMs may be designated as high-priority by both CMS and Wisconsin. Eligible Professionals should refer to the Wisconsin DHS (Department of Health Services) eHealth Program Quality Series: "Wisconsin High-Priority Electronic Clinical Quality Measures" for more information on this requirement and the list of outcome and high-priority CQMs designated by CMS or Wisconsin or both.

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

- Person and caregiver-centered experience and outcomes
- Patient safety
- Communication and care coordination
- Community/population health
- Efficiency and cost reduction
- Effective clinical care

Of the 53 approved CQMs, Eligible Professionals are required to report on six.

Zero is an acceptable value for the CQM denominator, numerator, and exclusion fields and will not prevent an Eligible Professional from demonstrating Meaningful Use or receiving an incentive payment. Eligible Professionals can meet the CQM requirements even if one or more CQM has "0" in the denominator, provided that this value was produced by CEHRT (certified electronic health record technology).

See the CMS Clinical Quality Measure Basics page of the CMS website to learn more about reporting CQMs. For a complete listing of CQMs, refer to the eCQM Library page of the CMS website.

Clinical Quality Measure Reporting Period

The following date ranges are the CQM reporting periods for the Meaningful User for Program Year 2019:

- The CQM reporting period for Eligible Professionals who are attesting to Meaningful Use criteria for the first time is any continuous 90-day period between January 1, 2019, and December 31, 2019.

- The CQM reporting period for Eligible Professionals who have successfully demonstrated any stage of Meaningful Use in a prior year is the full calendar year from January 1, 2019, through December 31, 2019.

Topic #16880

Wisconsin Medicaid-Recommended Clinical Quality Measures

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

eMeasure ID	National Quality Forum #	Measure Title	CMS (Centers for Medicare and Medicaid Services) Domain	Wisconsin Medicaid Recommendations	CMS Recommendations
CMS146v1	0002	Appropriate Testing for Children with Pharyngitis	Efficient Use of Healthcare Resources	B	Pediatric Recommended Core Measure
CMS137v1	0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Clinical Process/Effectiveness	A	
CMS165v1	0018	Controlling High Blood Pressure	Clinical Process/Effectiveness	A	Adult Recommended Core Measure
CMS156v1	0022	Use of High-Risk Medications in the Elderly	Patient Safety	B	Adult Recommended Core Measure
CMS155v1	0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Population/Public Health	A	Pediatric Recommended Core Measure
CMS138v1	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Population/Public Health	A	Adult Recommended Core Measure

CMS125v1	0031	Breast Cancer Screening	Clinical Process/Effectiveness	A	
CMS124v1	0032	Cervical Cancer Screening	Clinical Process/Effectiveness	A	
CMS153v1	0033	Chlamydia Screening for Women	Population/Public Health	A	Pediatric Recommended Core Measure
CMS126v1	0036	Use of Appropriate Medications for Asthma	Clinical Process/Effectiveness	A	Pediatric Recommended Core Measure
CMS117v1	0038	Childhood Immunization Status	Population/Public Health	A	Pediatric Recommended Core Measure
CMS166v2	0052	Use of Imaging Studies for Low Back Pain	Efficient Use of Healthcare Resources	B	Adult Recommended Core Measure
CMS122v1	0059	Diabetes: Hemoglobin A1c Poor Control	Clinical Process/Effectiveness	A	
CMS163v1	0064	Diabetes: LDL (Low Density Lipoprotein) Management	Clinical Process/Effectiveness	A	
CMS164v1	0068	IVD: Use of Aspirin or Another Antithrombotic	Clinical Process/Effectiveness	A	
CMS154v1	0069	Appropriate Treatment for Children with URI (Upper Respiratory Infection)	Efficient Use of Healthcare Resources	A	Pediatric Recommended Core Measure
CMS161v1	0104	MDD (Major Depressive Disorder): Suicide Risk Assessment	Clinical Process/Effectiveness	B	
CMS128v1	0105	Anti-depressant Medication Management	Clinical Process/Effectiveness	A	
		ADHD (Attention-			

CMS136v2	0108	Deficit/Hyperactivity Disorder): Follow-Up Care for Children Prescribed ADHD Medication	Clinical Process/Effectiveness	A	Pediatric Recommended Core Measure
CMS62v1	0403	HIV/AIDS: Medical Visit	Clinical Process/Effectiveness	A	
CMS52v1	0405	HIV/AIDS: PCP (Pneumocystis Jiroveci Pneumonia) Prophylaxis	Clinical Process/Effectiveness	A	
CMS77v1	TBD (proposed as 0407)	HIV/AIDS: RNA Control for Patients with HIV	Clinical Process/Effectiveness	A	
CMS2v2	0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Population/Public Health	A	Adult Recommended Core Measure Pediatric Recommended Core Measure
CMS68v2	0419	Documentation of Current Medications in the Medical Record	Patient Safety	A	Adult Recommended Core Measure
CMS69v1	0421	Preventive Care and Screening: BMI (Body Mass Index) Screening and Follow-Up	Population/Public Health	B	Adult Recommended Core Measure
CMS159v1	0710	Depression Remission at 12 Months	Clinical Process/Effectiveness	A	
CMS160v1	0712	Depression Utilization of the PHQ-9 Tool	Clinical Process/Effectiveness	A	
CMS75v1	TBD	Children Who Have Dental Decay or Cavities	Clinical Process/Effectiveness	A	Pediatric Recommended Core Measure
CMS65v2	TBD	Hypertension: Improvement in Blood Pressure	Clinical Process/Effectiveness	A	

CMS50v1	TBD	Closing the Referral Loop: Receipt of Specialist Report	Care Coordination	A	Adult Recommended Core Measure
CMS90v2	TBD	Functional Status Assessment for Complex Chronic Conditions	Patient and Family Engagement	B	Adult Recommended Core Measure

Eligibility

Topic #12038

Eligible Professionals for Promoting Interoperability Program

To be eligible to participate in the Wisconsin Medicaid PI (Promoting Interoperability) Program, an Eligible Professional must be enrolled in Wisconsin Medicaid as one of the following:

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

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

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

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

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

Financial Information

Topic #12120

835 Health Care Claim Payment/Advice Transaction

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

Topic #12118

Electronic Funds Transfer

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

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

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

Topic #12117

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

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

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

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

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

Topic #12105

Incentive Payment Information

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

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

Meaningful Use of Certified EHR Technology

Topic #13357

Definition of Meaningful Use

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

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

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

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

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

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

Topic #13358

Electronic Health Record Reporting Period for Meaningful Use

The EHR (electronic health record) reporting period is defined as the timeframe when Eligible Professionals report Meaningful Use to the Wisconsin Medicaid PI (Promoting Interoperability) Program.

In Program Year 2019, the EHR reporting period for all Eligible Professionals is any continuous 90 days between January 1, 2019, and December 31, 2019.

Topic #13377

Meaningful Use Criteria Overview

CMS (Centers for Medicare & Medicaid Services) has split the Meaningful Use criteria into separate stages that have been introduced over the course of the PI (Promoting Interoperability) Program through the federal rulemaking process.

- Stage 1 sets the baseline for electronic data capture and information sharing.

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

Meaningful Use Supporting Documentation

Eligible Professionals are required to submit Meaningful Use measure reports to support attestation. Required documentation includes:

- SRA (Security Risk Assessment) documentation. The SRA must be completed prior to December 31, 2019. For groups, practices may provide one SRA for all of their Eligible Professionals.
- Report(s) generated by certified EHR (electronic health record) technology supporting all Meaningful Use percentage-based measures (with numerators and denominators) and/or any other source material used by the Eligible Professionals to enter the Meaningful Use measure numerators and denominators.

Note: Eligible Professionals are not required to submit documentation supporting their CQMs (Clinical Quality Measures).

Applicable percentage-based measures include:

Modified Stage 2	Stage 3
• Objective 3: Computerized Provider Order Entry • Objective 4: Electronic Prescribing, Measure 1 • Objective 5: Health Information Exchange, Measure 1 • Objective 6: Patient-Specific Education, Measure 1 • Objective 7: Medication Reconciliation, Measure 1 • Objective 8: Patient Electronic Access, Measures 1 and 2 • Objective 9: Secure Electronic Messaging, Measure 1	• Objective 2: Electronic Prescribing, Measure 1 • Objective 4: Computerized Provider Order Entry, Measures 1-3 • Objective 5: Patient Electronic Access to Health Information, Measures 1 and 2 • Objective 6: Coordination of Care through Patient Engagement, Measures 1-3 • Objective 7: Health Information Exchange, Measures 1-3

Eligible Professionals should use SRA documentation and Meaningful Use reports to demonstrate that requirements were met for Meaningful Use measures during the EHR reporting period. For percentage-based measures, Eligible Professionals' EHR will electronically record the numerator and denominator and generate a report that includes the numerator, denominator, and percentage. If their Meaningful Use reports do not support the exact data entered in the Attestation section of the application, Eligible Professionals may also submit any other source material used to enter the Meaningful Use measure numerators and denominators.

Eligible Professionals are not required to submit documentation supporting their CQMs.

The following table further describes the acceptable types of documentation:

Documentation Type	Documentation Description	Submission Method	Required
Security Risk Analysis	For Objective 1, Protect Patient Health Information, supply detail on security risk analysis including: - Approach for assessment - Results of the assessment - Indication of who performed the assessment Detail on security update performed as a result of the security risk analysis including, but not limited to: - Update made - Date made Note: No exclusion is available for this objective.	Upload or email	Yes
Meaningful Use Reports	This type of documentation can be used for: - Percentage-based measures - Any claimed exclusions where the report displays a "0" for the or the report displays a denominator that is less than a threshold specified in the measure exclusion criteria. (For example, if the requirement states that an exclusion may be used by an Eligible Professional with "less than 100 orders" and the report	Upload or email	Yes

	supports that the Eligible Professional had less than 100 orders.) - If Eligible Professionals' Meaningful Use reports do not support the exact data entered in the Attestation section of the application, they may also submit any other source materials used to enter the Meaningful Use measure numerators and denominators.		

Meaningful Use Audit Documentation

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

Topic #19217

Consolidated Public Health Objective

For Modified Stage 2 Meaningful Use in Program Years 2015 through 2018, Eligible Professionals are required to attest to a consolidated public health objective, which has three measure options. The following is an overview of the public health reporting objective for Eligible Professionals with details on how to successfully demonstrate active engagement and obtain supporting documentation for public health reporting.

Public Health Reporting Objective and Measures

The public health reporting objective requires Eligible Professionals to demonstrate active engagement with a public health agency to submit electronic public health data from CEHRT (certified electronic health record technology). The following table shows the three measure options that make up the public health reporting objective.

Measure Number and Name	Measure Specification	Maximum Times Measure Can Count	Exclusion Criteria
			At least one of the following is true: - Does not administer any immunizations during the EHR reporting period.

Measure 1 — Immunization Registry Reporting	The Eligible Professional is in active engagement with a public health agency to submit immunization data.	1	▪ Operates in a jurisdiction for which no immunization registry is capable of accepting the specific Meaningful Use standards at the start of the EHR reporting period. ▪ Operates in a jurisdiction where no immunization registry has declared readiness at the start of the EHR reporting period.
Measure 2 — Syndromic Surveillance Reporting	The Eligible Professional is in active engagement with a public health agency to submit syndromic surveillance data.	1	**At least one** of the following is true: ▪ Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction. ▪ Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data per specific Meaningful Use standards at the start of the EHR reporting period. ▪ Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data at the beginning of the EHR reporting period.
			At least one of the following is true: ▪ Does not diagnose or treat any disease or condition associated with, or collect relevant data that is required by, a specialized registry in their jurisdiction during the EHR reporting

Measure 3 — Specialized Registry Reporting*	The Eligible Professional is in active engagement with a public health agency to submit data to a specialized registry.	2	period. • Operates in a jurisdiction for which no specialized registry is capable of accepting electronic transaction in the specific Meaningful Use standards at the start of the EHR reporting period. • Operates in a jurisdiction where no specialized registry for which the Eligible Professional is eligible has declared readiness to receive electronic registry transactions at the start of the EHR reporting period.

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

Eligible Professionals in Program Year 2018 are required to attest to any two of the three measures.

Demonstrating Active Engagement for Public Health Reporting

For the Modified Stage 2 public health reporting objective, Eligible Professionals are required to be in active engagement with a public health agency to submit electronic public health data from CEHRT. Active engagement means the Eligible Professional is progressing toward sending production data or is sending production data to a public health agency or clinical data registry. Submitting production data shows that an Eligible Professional regularly reports data generated through clinical processes involving patient care from CEHRT to a public health program using appropriate standards and specifications.

An Eligible Professional can meet a public health reporting measure by registering to submit data and demonstrating any of the following Modified Stage 2 active engagement options*:

- Option 1 — Completed Registration to Submit Data: The Eligible Professional registered to submit data with the public health agency or, where applicable, with the clinical data registry to which the information is being submitted; registration was completed no later than 60 days after the start of their EHR reporting period; and the Eligible Professional is awaiting invitation to begin testing and validation. With this option:
  - Eligible Professionals are able to meet the measure even when the public health agency or clinical data registry has limited resources to initiate the testing and validation process.
  - Eligible Professionals are able to meet the measure by registering their intent to report with a registry if a registry declares readiness at any point in the calendar year after the initial 60 days. (However, if an Eligible Professional had already planned to exclude based on the registry not being ready to allow for registrations of intent within the first 60 days of the reporting period, they may still exclude for that calendar year.)
  - Eligible Professionals who have completed registration in previous years do not need to submit a new registration to meet this requirement for each EHR reporting period as long as the registration accurately reflects their intent to submit data. Eligible Professionals whose completed registrations do not accurately reflect their intent to submit data for a public health measure are required to update their registration no later than 60 days after the start of their EHR

reporting period.

For example, if an Eligible Professional previously only registered intent to submit immunization data and has now decided to also attest to the specialized registry measure for cancer reporting, the Eligible Professional will have to update the existing registration.

- Option 2 — Testing and Validation: The Eligible Professional is in the process of testing and validation of the electronic submission of data.
- Option 3 — Production: The Eligible Professional has completed testing and validation of the electronic submission and is electronically submitting production data to the public health agency or clinical data registry.

**Note:* The active engagement options included in Modified Stage 2 replace the ongoing submission requirement in Stage 2; however, they should not be considered mutually exclusive. Eligible Professionals who have already planned for and/or acted toward meeting any of the previous Meaningful Use requirements (Stage 1 or Stage 2 public health reporting objectives) may use those actions to count toward meeting the active engagement options under Modified Stage 2. Multiple exclusions apply.

Public Health Reporting Exclusions

There are multiple exclusions for each of the public health reporting measures. Claiming an exclusion for a measure does not count toward the total number of public health reporting measures an Eligible Professional is required to meet. Instead, to meet the public health objective, an Eligible Professional is required to do one of the following:

- Demonstrate active engagement with a public health agency for at least the minimum number of measures for their scheduled stage.
- Demonstrate active engagement with a public health agency for less than the minimum number of measures for their scheduled stage, and claim an applicable exclusion for all remaining measures.

Eligible Professionals who do not collect appropriate or relevant data to submit to a public health agency may be able to claim an exclusion or pick another public health reporting measure. If an Eligible Professional meets the exclusion criteria, they can claim the exclusion to the measure. If an Eligible Professional is part of a group that submits data to a registry, but the Eligible Professional does not contribute to that data (e.g., does not administer immunizations), the Eligible Professional should not attest to meeting the measure and should claim the exclusion.

Although exclusions are available for the public health reporting measures, the Wisconsin Medicaid EHR Incentive Program does not formally grant exclusions to Eligible Professionals or offer documentation for Eligible Professionals to use when claiming an exclusion. Eligible Professionals are required to self-attest to exclusions in the attestation system based on CMS exclusion criteria. It is the Eligible Professional's responsibility to claim an exclusion and maintain the proper documentation to substantiate the attestation.

Topic #19218

Registration for Public Health Program

All Eligible Professionals participating in Meaningful Use (regardless of scheduled stage) should register with DPH (Wisconsin Division of Public Health) for the public health program and/or registry (e.g., immunizations) to which they intend to electronically submit data. In January 2014, DPH launched PHREDS (Public Health Registration for Electronic Data Submission System), a Microsoft® SharePoint® site where Eligible Professionals register their intent to submit data from CEHRT to a public health program/registry. Eligible Professionals who would like to electronically submit data from CEHRT to a public health program are required to register through PHREDS.

After a registration form is successfully submitted in PHREDS, Eligible Professionals receive a registration confirmation email and are put into a queue with the public health registries for which they have registered. Eligible Professionals in the queue will await an

invitation from registry personnel to begin the onboarding process. Onboarding is the testing and validation process Eligible Professionals and public health programs engage in prior to the achievement of ongoing submission of production data. Each registry has a separate process for onboarding Eligible Professionals, but all use PHREDS to manage registrations and the onboarding queue.

In order to meet active engagement option one, all Eligible Professionals who collect the appropriate data should register their intent to submit data to the relevant public health registry no later than 60 days after the start of their EHR reporting period. Based on the registry's onboarding policies, Eligible Professionals may not be invited to further participate in the onboarding process before their EHR reporting period ends; however, they will have successfully demonstrated the public health reporting objective criteria for Active Engagement Option 1 — Completed Registration to Submit Data (and would not have to claim an exclusion).

Meaningful Use Acknowledgements for Public Health Programs

Meaningful Use Acknowledgements are the mechanism DPH uses to acknowledge that Eligible Professionals have registered, completed a test, or reached ongoing submission of production data from CEHRT. The Wisconsin Medicaid EHR Incentive Program strongly encourages Eligible Professionals to retain these documents (i.e., registration confirmation email and Acknowledgements file) because they are the only forms of documentation produced by DPH for this purpose.

The Wisconsin Medicaid EHR Incentive Program also recommends that all Eligible Professionals save a copy of the Acknowledgements file (in Excel format) dated after the end of their EHR reporting period, even if they are still in the onboarding queue or have achieved ongoing submission of production data. In the event of an audit, Eligible Professionals will use the Acknowledgments file to substantiate their Meaningful Use attestation. The auditor will want to see an Acknowledgments file dated after the end of the EHR reporting period being audited, to confirm the organization's or site's active engagement status with the public health registry at that time. To facilitate the audit process, all Eligible Professionals are encouraged to save a printed or PDF copy of the PHREDS page explaining the contents of the Acknowledgements file.

Specialized Registries

Modified Stage 2 allows for a wide range of reporting options now and in the future, explicitly stating that Eligible Professionals may choose to report to clinical data registries to satisfy the measure. This means the category of specialized registries used to satisfy the specialized registry measure is not limited to those sponsored by state or local public health agencies, and Eligible Professionals may work with specialized registries outside of DPH to satisfy the Specialized Registry Reporting measure. The registries outside of DPH might include applicable registries sponsored by the Centers for Disease Control and Prevention, national medical specialty organizations, patient safety organizations, and/or quality improvement organizations. This flexibility in use of specialized registries allows Eligible Professionals to continue in the direction they may have already planned for reporting to specialized registries.

The DPH does not provide registration, administrative onboarding, compliance, or audit support to Eligible Professionals trying to meet the Specialized Registry Reporting measure if the an Eligible Professional has chosen to use a registry outside of those offered by DPH. Eligible Professionals are strongly encouraged to consider the availability of supporting documentation before attesting to the use of a specialized registry outside of those offered by DPH. In order to be considered a specialized registry by the Wisconsin Medicaid EHR Incentive Program, the agency/registry must:

- Publicly declare readiness to receive electronic data submissions.
- Publicly declare the ability to support the registration/onboarding and production processes.
- Provide proper documentation to providers to support active engagement.

Documentation maintained by an Eligible Professional to support electronic data submission to the specialized registry may also be used, in addition to any documentation provided by the agency/registry.

Eligible Professionals will be prompted to attest to the name of the specialized registry during the application process. The Wisconsin Medicaid EHR Incentive Program also encourages Eligible Professionals to upload documentation supporting their attestation. If an Eligible Professional is intending to attest to a specialized registry sponsored by DPH, appropriate documentation

would be the Acknowledgements file provided on the PHREDS SharePoint site.

Topic #19219

Modified Stage 2 Meaningful Use Audit Documentation

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

Eligible Professionals should note that measures listed below with an asterisk (*) had an alternate exclusion available for select Eligible Professionals in either 2015 or 2016. Alternate exclusions were based on an Eligible Professional's scheduled Stage of Meaningful Use and were available for Program Year 2016 in some limited cases. According to the PI Program — Stage 3 and Modifications to Meaningful Use in 2015 through 2017 Final Rule (80 FR 62788), the federal CMS (Centers for Medicare and Medicaid Services) will not require documentation to claim an alternate exclusion for a measure to which an Eligible Professional did not plan to attest.

Example #	Requirement	Measure	Examples of Supporting Documentation
1	Must report and meet the required threshold/answers for all General Requirements and measures for all objectives	General requirements 01-02 Measures for Objectives 03-09	▪ Meaningful Use reports/dashboard produced by CEHRT (certified electronic health record technology) ▪ Documentation on how the attestations were created, specifically how the numerators/denominators were calculated, including rationale taken into account for inclusion/exclusion of data ▪ Electronic medical record for a Medicaid member verifying required measures have been captured electronically in the CEHRT
2	General Requirement 01: Percent of CEHRT Use	Must have 50 percent or more of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with CEHRT.	▪ List of total encounters with detail including date, patient identifier, payer, and rendering provider ▪ List of encounter with CEHRT with detail on location and CEHRT used
3	General Requirement 02: Unique Patients in CEHRT	Must have 80 percent or more of their unique patient data in the CEHRT during the EHR reporting period.	List of all unique patients with indication of whether they are in CEHRT (If practicing at multiple locations, indicate which patients were seen in what location.)

4	Objective 1: Protect Patient Health Information	Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of electronic protected health information (ePHI) created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the Eligible Professional's risk management process.	- Detail on security risk analysis including, but not limited to: 1. Approach for assessment 2. Results of the assessment 3. Indication of who performed the assessment - Detail on security update performed as a result of the security risk analysis including, but not limited to: 1. Update module 2. Date made
5	Objective 2: CDS (Clinical Decision Support) — Measure 1	Implement five CDS interventions related to four or more CQMs (clinical quality measures) at a relevant point in patient care for the entire EHR reporting period. Absent four CQMs related to an Eligible Professional's scope of practice or patient population, the CDS interventions must be related to high priority health conditions.	- Description of what CDS interventions have been implemented with explanation of how the CDS interventions are aligned with four or more CQMs (documentation should be uploaded pre-payment) - Audit log showing the enabling of the CDS functionality with the time/date stamp - Screenshots from CEHRT demonstrating implementation of the CDS rules
6	Objective 2: CDS — Measure 2	The Eligible Professional has enabled and implemented the functionality for drug-drug and drug allergy interaction checks	- Audit log showing the enabling of the drug-drug and drug-allergy interaction checks with a time/date stamp - Screenshots from the CEHRT demonstrating the drug/drug and drug/allergy interaction checks - Documentation on exclusion

		for the entire EHR reporting period.	qualification — proof the Eligible Professional wrote fewer than 100 medication orders during the EHR reporting period
7	Objective 3: CPOE (computerized provider order entry) — Measure 1 — Medication Orders	More than 60 percent of medication orders created by the Eligible Professional during the EHR reporting period are recorded using computerized provider order entry	ı Random sampling of patient records ı Rationale for exclusion/inclusion of patient records ı List of individuals who entered CPOE with their credentials ı Policies and procedures on CPOE ı Documentation on exclusion qualification — proof they wrote fewer than 100 medication orders
8	Objective 3: CPOE — Alternate Measure 1 — Medication Orders	For providers scheduled for Stage 1 in 2015: ı For Stage 1 providers in 2015, more than 30 percent of all unique patients with at least one medication in their medication list seen by the Eligible Professional during the EHR reporting period have at least one medication order entered using CPOE ı More than 30 percent of medication orders created by the Eligible Professional during the EHR reporting period are recorded using CPOE	ı Random sampling of patient records ı Rationale for exclusion/ inclusion of patient records ı List of individuals who entered CPOE with their credentials ı Policies and procedures on CPOE ı Documentation on exclusion qualification — proof they wrote fewer than 100 medication orders
			ı Random sampling of patient records

9	Objective 3: CPOE — Measure 2 — Laboratory Orders	More than 30 percent of laboratory orders created by the Eligible Professional during the EHR reporting period are recorded using computerized provider order entry.*	ı Rationale for exclusion/ inclusion of patient records ı List of individuals who entered CPOE with their credentials ı Policies and procedures on CPOE ı Documentation on exclusion qualification — proof they wrote fewer than 100 laboratory orders
10	Objective 3: CPOE — Measure 3 — Radiology Orders	More than 30 percent of radiology orders created by the Eligible Professional during the EHR reporting period are recorded using computerized provider order entry.*	ı Random sampling of patient records ı Rationale for exclusion/ inclusion of patient records ı List of individuals who entered CPOE with their credentials ı Policies and procedures on CPOE ı Documentation on exclusion qualification — proof they wrote fewer than 100 radiology orders
11	Objective 4: eRx (Electronic Prescribing)	More than 50 percent of all permissible prescriptions written by the Eligible Professional are queried for a drug formulary and transmitted electronically using CEHRT.	ı Random sampling of patient records ı Rationale for exclusion/ inclusion of patient records ı Rationale for exclusion/ inclusion of prescriptions ı Certified electronic health record technology screenshots verifying formularies utilized ı Documentation on exclusion 1 qualification — proof they wrote fewer than 100 permissible prescriptions ı Documentation on exclusion 2 qualification — on lack of pharmacies that accept electronic prescriptions within 10 miles of the Eligible Professional's practice location at the start of their EHR reporting period.
			ı Random sampling of patient records

12	Objective 4: eRx — Alternate Measure	For providers scheduled for Stage 1 in 2015, more than 40 percent of all permissible prescriptions written by the Eligible Professional are transmitted electronically using CEHRT.	ı Rationale for exclusion/ inclusion of patient records ı Rationale for exclusion/ inclusion of prescriptions ı Documentation on exclusion 1 qualification — proof they wrote fewer than 100 permissible prescriptions
13	Objective 5: Health Information Exchange	The Eligible Professional that transitions or refers their patient to another setting of care or provider of care must: 1. Use CEHRT to create a summary of care record 2. Electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals*	ı Random sampling of patient records ı Sample of a summary of care record ı Rationale for exclusion/ inclusion of patient records ı Supporting documentation that the exchange mechanism complies with the privacy and security protocols for ePHI under the Health Insurance Portability and Accountability Act of 1996 ı Log of exchange that took place during the EHR reporting period ı Documentation on exclusion qualification — proof the Eligible Professional transfers or refers a patient to another setting of care or provider less than 100 times during the EHR reporting period
14	Objective 6: Patient Specific Education	Patient-specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the Eligible Professional during the EHR reporting period.*	ı Documentation to show use of patient education based on information in the system (e.g., screenshots or EHR generated reports) ı Sample of patient record indicating resources provided and rationale for the education resource — the connection to their clinically relevant information ı Documentation on exclusion qualification — proof the Eligible

			Professional had no office visits during the EHR reporting period
15	Objective 7: Medication Reconciliation	The Eligible Professional performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the Eligible Professional.*	ı Random sampling of patient records ı Rationale for inclusion/exclusion of patient records ı Documentation on exclusion qualification — proof the Eligible Professional was not the recipient of any transitions of care during the EHR reporting period
16	Objective 8: Patient Electronic Access — Measure 1	More than 50 percent of all unique patients seen by the Eligible Professional during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the Eligible Professional's discretion to withhold certain information.	ı Eligible Professional Policy and Procedure documentation ı Rationale for exclusion/inclusion of patient records ı Documentation on how access was granted to patients within a set timeline ı Electronic Health Record audit logs of patient access processing ı Screenshots verifying existence of Patient Portal or ePHR solution ı Random sampling of patient records ı Documentation on exclusion 1 qualification — rationale on how the Eligible Professional neither orders nor creates information listed for inclusion in the measure
	Objective 8: Patient	For an EHR reporting period in 2015 and 2016, at least one patient seen by the Eligible Professional during the EHR reporting period (or patient-authorized representative) views, downloads, or transmits their health information to a third party during the EHR reporting period.*	ı Eligible Professional Policy and Procedure documentation ı Rationale for exclusion/inclusion of patient records ı Documentation on how access was granted to patients within a set timeline ı Electronic Health Record audit logs of patient access processing ı Random sampling of patient records ı Documentation on exclusion 1

17	Electronic Access — Measure 2	For an EHR reporting period in 2017, more than five percent of unique patients seen by the Eligible Professional during the EHR reporting period (or his/her authorized representative) view, download, or transmit to a third party their health information during the EHR reporting period.	qualification — rationale on how the Eligible Professional neither orders nor creates information listed for inclusion in the measure - Documentation on exclusion 2 qualification — proof that 50 percent or more of the Eligible Professional's patient encounters take place in a county that does not have 50 percent or more of its housing units with 4 Mbps broadband availability
18	Objective 9: Secure Electronic Messaging	For an EHR reporting period in 2015, the capability for patients to send and receive a secure electronic message with the Eligible Professional was fully enabled during the EHR reporting period.* For an EHR reporting period in 2016, for at least one patient seen by the Eligible Professional during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or representative), or in response to a secure message sent by the patient (or representative) during the EHR reporting period. For an EHR reporting period in 2017, for more than five percent of unique patients seen by the Eligible Professional during the EHR reporting	- Random sampling of patient records - Rationale for exclusion/ inclusion of patient records - 2015: Documentation that the functionality was fully enabled during the EHR reporting period - 2016: Documentation that at least one patient was sent a secure messaging using the electronic messaging function of CEHRT, during the EHR reporting period - Documentation on exclusion 1 qualification — proof the Eligible Professional had no office visits during the EHR reporting period - Documentation on exclusion 2 qualification — proof the Eligible Professional conducts at least 50 percent of their patient encounters in a county that does not have at least 50 percent of its housing units with 4 Mbps broadband availability

		period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or representative), or in response to a secure message sent by the patient (or representative) during the EHR reporting period.	according to the latest information available from the Federal Communications Commission on the first day of the EHR reporting period
19	Objective 10: Public Health Reporting — Measure 1 — Immunization Registry Reporting	The Eligible Professional is in active engagement with a public health agency to submit immunization data.*	ı Documentation of the Eligible Professional's registration, onboarding, and/or ongoing submission with the DPH (Wisconsin Division of Public Health) ı Documentation on exclusion 1 qualification — proof the Eligible Professional does not administer any immunizations to any of the populations for which data is collected by the DPH during the EHR reporting period
20	Objective 10: Public Health Reporting — Measure 2 — Syndromic Surveillance Reporting	The Eligible Professional is in active engagement with a public health agency to submit syndromic surveillance data.*	ı Documentation of the Eligible Professional's registration, onboarding, and/or ongoing submission with the DPH ı Documentation on the mechanism the Eligible Professional has chosen to report syndromic surveillance data ı Documentation on exclusion 1 qualification — proof the Eligible Professional is not in a category of providers from which ambulatory syndromic surveillance data is collected by the DPH
			ı Documentation of the Eligible Professional's registration, onboarding, and/or ongoing submission with the

21	Objective 10 — Public Health Reporting — Measure 3 — Specialized Registry Reporting	The Eligible Professional is in active engagement to submit data to a specialized registry.*	DPH or other specialized registry - Documentation on exclusion 1 qualification — proof that the Eligible Professional does not diagnose or treat any disease or condition associated with, or collect relevant data that is collected by, a specialized registry in their jurisdiction during the EHR reporting period (e.g., cancer registry) (Two actions must be documented to claim this exclusion: 1. determine if the jurisdiction [state, territory, etc.] endorses or sponsors a registry, and 2. determine if a National Specialty Society or other specialty society with which the provider is affiliated, endorses, or sponsors a registry.) - Documentation on exclusion 3 qualification — proof the Eligible Professional operates in a jurisdiction where no specialized registry for which the Eligible Professional is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period

Topic #20277

Requirements for Stage 3 Meaningful Use

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

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

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

- Coordination of Care through Patient Engagement — Eligible Professionals must attest to all three measures and must either meet the thresholds or satisfy an exclusion for at least two measures to meet the objective.
- Health Information Exchange — Eligible Professionals must attest to all three measures and must either meet the thresholds or satisfy an exclusion for at least two measures to meet the objective.
- Public Health Reporting — Eligible Professionals must either attest or satisfy an exclusion for two measures. More information is detailed in the section below.

Stage 3 Public Health Reporting Objective

The public health reporting objective requires Eligible Professionals to demonstrate active engagement with a public health agency to submit electronic health data from CEHRT (Certified Electronic Health Records Technology). The public health reporting objective contains five measure options. Measure 3 — Electronic Case Reporting is available to Eligible Professionals in Program Year 2019, but it is not required. In Program Year 2019, all Eligible Professionals must do one of the following:

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

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

Patient Volume

Topic #12098

Eligible Member Patient Volume

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

- At least 30 percent of their patient volume is attributed to eligible members over a continuous 90-day period in the calendar year preceding the payment year or during the 12 months prior to the date of attestation.
- Pediatricians will be considered eligible if 20 percent of their patient encounter volume is attributable to eligible members but will receive two-thirds of the incentive amounts. If a pediatrician's patient encounter volume is 30 percent or higher, the incentive payments are the same as any other Eligible Professional.

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

Definition of Eligible Members

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

Definition of Patient Encounter

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

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

Standard Deduction

The federal regulations governing the Medicaid PI Program stipulate that an eligible member is an individual whose services are reimbursed through Medicaid (Title XIX). Since ForwardHealth is funded by both Medicaid (Title XIX) and the CHIP (Children's Health Insurance Program) (Title XXI), Eligible Professionals may be unable to distinguish encounters with eligible members from encounters with non-eligible members when determining their patient volume. To assist Eligible Professionals in determining their eligible patient encounters, the Wisconsin Medicaid PI Program will calculate a standard deduction. The standard deduction for Program Year 2019 is 4.11 percent.

To calculate eligible patient encounters, Eligible Professionals should multiply the total number of eligible member encounters by a factor of (1 - 0.0411), which is 0.9589, and then divide that number by the total number of patient encounters. The final number

should be rounded to the nearest whole number (i.e., .01 through .49 should be rounded down to the nearest whole number, and .50 through .99 should be rounded up to the nearest whole number).

Individual and Group Practice Methodologies

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

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

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

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

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

Topic #12099

Needy Individual Patient Volume

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

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

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

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

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

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

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

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

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

Topic #12101

Example of Calculating Group Practice Patient Volume

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

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

Eligible Based on Provider Type	Provider Type	Total Encounters (Eligible Members/Total)	Percentage of Eligible Member Encounters
Yes	Physician	80/200	40 percent
Yes	Nurse Practitioner	50/100	50 percent
Yes	Physician	0/100	0 percent
No	RN (Registered Nurse)	150/200	75 percent
No	Pharmacist	80/100	80 percent
Yes	Physician	30/300	10 percent
Yes	Dentist	5/100	5 percent
Yes	Dentist	60/200	30 percent

In this scenario, there are 1300 encounters in the selected 90-day period. Of the 1300 encounters, 455 are attributable to eligible members, or 35 percent. The next step is to apply the standard deduction (1 - 0.0411 = 0.9589) to the number of eligible members.

455 * 0.9589 = 436.2995

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

436.2995 / 1300 = 0.335615 or 33.60 percent

Therefore, the group practice patient volume is 33.60 percent, which is rounded to the nearest whole number of 34 percent, and is eligible for the Wisconsin Medicaid PI Program.

Eligible Professionals should note that even though one dentist's eligible member encounter percentage was only 5 percent and one physician's eligible member encounter percentage was 10 percent, when included in the group practice patient volume, both are eligible for the program when registering with the group practice patient volume. The physician whose eligible member encounter percentage is zero is not eligible for the program because they did not render services to at least one eligible member during the 90-day period; however, if the physician is new to practicing medicine (e.g., a recent graduate of an appropriate training program), they would be eligible for the program because they do not need to provide proof of an encounter.

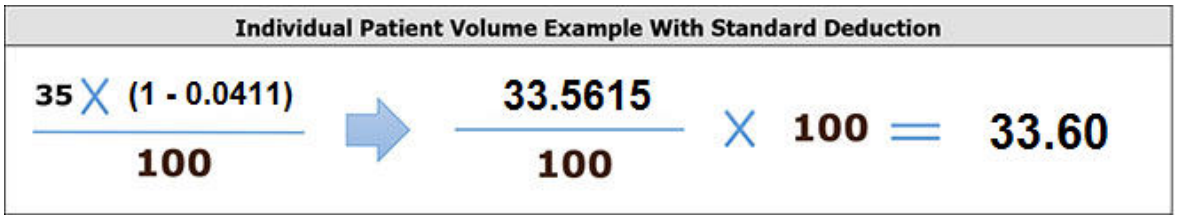
Topic #12100

Example of Calculating Individual Patient Volume

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

Eligible Professionals may be unable to distinguish between some eligible members and some non-eligible members when determining their patient volume. The Wisconsin Medicaid PI (Promoting Interoperability) Program only considers services provided to members who are eligible to be reimbursed with funding directly from Medicaid (Title XIX) to be a patient encounter. Eligible Professionals may be unable to determine where funding for eligible members comes from, so in order to assist Eligible Professionals in determining their eligible patient encounters, the Wisconsin Medicaid PI Program will calculate a standard deduction. The standard deduction for Program Year 2019 is 4.11 percent.

To figure out the eligible member patient encounters, Eligible Professionals must multiply their total eligible member encounter patient volume by a factor of (1 - 0.0411) or 0.9589 and then divide that number by their total eligible member patient encounter volume.



So the final eligible member patient encounter volume is 33.5615 encounters out of 100 total, or 33.60 percent, rounded to the nearest whole number, 34 percent.

Therefore, 33 percent of the Eligible Professional's patient volume is eligible members and the Eligible Professional fulfills the patient volume requirement for the Wisconsin Medicaid PI Program. Eligible Professionals should note that the Wisconsin Medicaid PI Program will not round up to meet the minimum patient volume threshold. All patient volumes reported that are below 30 percent (including those at or below 29.99 percent) will be deemed ineligible.

Topic #12078

Patient Volume Requirements and Calculations

In addition to other PI (Promoting Interoperability) Program requirements, Eligible Professionals must meet patient volume thresholds over the course of a 90-day period.

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

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

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

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

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

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

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

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

- Eligible member patient volume
- Needy individual patient volume

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

Topic #18077

Documentation Requirements

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

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

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

Eligible Professionals Reporting Individual Patient Volume

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

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

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

Eligible Professionals Reporting Group Practice Patient Volume

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

- Summary report of the provider information included in the group practice patient volume calculation

- Detail report (used to enter patient volume) that supports the information provided in the summary report

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

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

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

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

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

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

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

Submission Requirements

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

Uploading Documentation

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

required supporting documentation, Eligible Professionals should refer to the Wisconsin Medicaid Promoting Interoperability Program User Guide for Eligible Professionals on the User Guides page of the ForwardHealth Portal.

Emailing Documentation

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

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

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

Registration and Applying

Topic #12057

Individuals Applying for the Promoting Interoperability Program

A secure Provider account on the ForwardHealth Portal is required to apply for the Wisconsin Medicaid PI (Promoting Interoperability) Program. All applications must be completed via a secure Provider Portal account.

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

- The Eligible Professional needs to first log in to the Portal. If the Eligible Professional does not have a Portal account, they need to obtain one. The Eligible Professional should refer to the Account User Guide on the User Guides page of the Portal for more information on obtaining a Portal account.
- The Eligible Professional needs to click on the Wisconsin Medicaid PI Program link in the Quick Link box.
- The Eligible Professional will have to designate payment to either him- or herself or to the organization.

Topic #12040

Organizations Applying for the Promoting Interoperability Program on Behalf of Eligible Professionals

A secure Provider Portal account is required to apply for the Wisconsin Medicaid PI (Promoting Interoperability) Program. All applications must be completed via a secure Provider ForwardHealth Portal account.

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

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

Topic #12039

Registration for the Promoting Interoperability Program with CMS

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

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

Topic #12058

Required Information When Starting the Promoting Interoperability Program Application

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

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

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

Topic #12077

Reviewing, Confirming, and Submitting the PI Program Application

After completing attestations for the PI (Promoting Interoperability) Program, the Eligible Professional will be asked to review all answers provided. An error-checking function will identify any errors found in the application.

Final submission will require an electronic signature by providing the preparer or the Eligible Professional's initials, the Eligible Professional's NPI (National Provider Identifier) and the Eligible Professional's personal TIN (tax identification number). If completed through the use of an authorized preparer, that preparer will also need to include their name and relationship to the Eligible Professional and then electronically sign the application before submission. Once the Wisconsin Medicaid PI Program application has been completed and submitted, an email notification will be sent to confirm the application's submission. After an application is successfully submitted and approved, Eligible Professionals can expect payments within 45 days.

Resources for Promoting Interoperability Program

Topic #18097

Technical Assistance Services

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

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

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

Provider Enrollment and Ongoing Responsibilities

8

Archive Date:03/02/2020

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

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

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

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

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

Topic #200

Confidentiality and Proper Disposal of Records

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

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

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

HIPAA Privacy and Security Regulations

Definition of Protected Health Information

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

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

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

Requirements Regarding "Unsecured" Protected Health Information

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

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

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

Actions Required for Proper Disposal of Records

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

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

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

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

Wisconsin Confidentiality Laws

Wis. Stat. § 134.97 requires providers and their business partners who are not subject to HIPAA regulations to comply with Wisconsin confidentiality laws pertaining to the disposal of health care and related records containing PHI.

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

"Personally Identifiable Data" Protected

According to Wis. Stat. § 134.97(1)(e), the types of records protected are those containing "personally identifiable data."

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

Actions Required for Proper Disposal of Records

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

Businesses Affected

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

Continuing Responsibilities for All Providers After Ending Participation

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

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

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

Penalties for Violations

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

- Fines up to $1.5 million per calendar year

- Jail time
- Federal HHS Office of Civil Rights enforcement actions

For entities not subject to HIPAA, Wis. Stat. § 34.97(4) imposes penalties for violations of confidentiality laws. Any provider or provider's business partner who violates Wisconsin confidentiality laws may be subject to fines up to $1,000 per incident or occurrence.

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

Topic #201

Financial Records

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

Topic #202

Medical Records

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

Topic #199

Member Access to Records

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

Fees for Health Care Records

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

Per Wis. Stat. § 146.81(4), health care records are all records related to the health of a patient prepared by, or under the supervision of, a health care provider.

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

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

The Wisconsin DHS (Department of Health Services) adjusts the amounts a provider may charge for providing copies of a member's health care records yearly per Wis. Stat. § 146.83(3f)(c).

Topic #16157

Policy Requirements for Use of Electronic Signatures on Electronic Health Records

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

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

Electronic Signature Definition

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

Some examples include:

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

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

Benefits of Using Electronic Signatures

The use of electronic signatures will allow providers to:

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

Electronic Signature Requirements

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

General Requirements

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

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

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

Electronic Health Record Signature Requirements

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

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

Topic #203

Preparation and Maintenance of Records

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

Topic #204

Record Retention

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

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

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

Maintaining Confidentiality of Records

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

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

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

Reviews and Audits

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

Topic #205

Records Requests

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

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

Request From a Member or Authorized Person

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

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

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

    The letter must be sent to the following address:

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

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

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

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

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

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

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

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

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

Request for a Statement From a Dual Eligible

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

Topic #1646

Release of Billing Information to Government Agencies

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

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

Ongoing Responsibilities

Topic #220

Accommodating Members With Disabilities

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

Topic #219

Civil Rights Compliance (Nondiscrimination)

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

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

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

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

- Denial of aid, care, services, or other benefits
- Segregation or separate treatment
- Restriction in any way of any advantage or privilege received by others (There are some program restrictions based on eligibility classifications.)
- Treatment different from that given to others in the determination of eligibility
- Refusing to provide an oral language interpreter to persons who are considered LEP (limited English proficient) at no cost to the LEP individual in order to provide meaningful access
- Not providing translation of vital documents to the LEP groups who represent 5 percent or 1,000, whichever is smaller, in the provider's area of service delivery

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

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

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

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

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

Title VI of the Civil Rights Act of 1964

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

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

Title VII of the Civil Rights Act of 1964

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

Federal Rehabilitation Act of 1973, Section 504

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

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

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

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

Americans With Disabilities Act of 1990

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

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

Age Discrimination Act of 1975

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

Topic #198

Contracted Staff

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

When contracting services, providers are required to ensure contracted agencies are qualified to provide services, meet all ForwardHealth and program requirements, and maintain records in accordance with the requirements for the provision of services.

Medicaid requirements do not relieve contracted agencies of their own regulatory requirements. Contracted agencies are required to continue to meet their own regulatory requirements, in addition to ForwardHealth requirements.

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

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

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

Topic #216

Examples of Ongoing Responsibilities

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

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

Topic #217

Keeping Information Current

Changes That Require ForwardHealth Notification

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

- Address(es) — practice location and related information, mailing, PA (prior authorization), and/or financial

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

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

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

- Incorrect reimbursement

- Misdirected payment
- Claim denial
- Suspension of payments or cancellation of provider file if provider mail is returned to ForwardHealth for lack of a current address

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

Notifying ForwardHealth of Changes

Providers can notify ForwardHealth of changes using the demographic maintenance tool.

Providers Enrolled in Multiple Programs

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

Providers Licensed or Certified by the Division of Quality Assurance

Providers licensed or certified by the DQA (Division of Quality Assurance) are required to notify the DQA of changes to physical address, changes of ownership, and facility closures by emailing Lisa.Imhof@dhs.wisconsin.gov.

Topic #577

Legal Framework

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

- Federal Law and Regulation:
  - Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI
  - Regulation — Title 42 C.F.R. Parts 430-498 and Parts 1000-1008 (Public Health)
- Wisconsin Law and Regulation:
  - Law — Wis. Stat. §§ 49.43-49.499, 49.665, and 49.473
  - Regulation — Wis. Admin. Code chs. DHS 101, 102, 103, 104, 105, 106, 107, and 108

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

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

Topic #17097

Licensure Information

Licensed providers are required to keep all licensure information, including license number, grant and expiration dates, and physical location as applicable (e.g., hospital providers), current with ForwardHealth.

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

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

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

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

Topic #15157

Recovery Audit Contractor Audits

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

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

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

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

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

Affected Providers

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

Additional Information

Any questions regarding the RAC program should be directed to HMS at 855-699-6289. Refer to the RAC website for additional information regarding HMS RAC activities.

Topic #13277

< h1>Reporting Suspected Waste, Fraud, and Abuse< /h1> < p>The Wisconsin < acronym title="Department of Health Services">DHS< /acronym> < acronym title="Office of Inspector General">OIG< /acronym> investigates fraud and abuses including, but not limited to, the following:< /p> < ul> < li>Billing Medicaid for services or equipment that were not provided< /li> < li>Submitting false applications for a DHS-funded assistance program such as Medicaid, BadgerCare Plus, < acronym title="Special Supplemental Nutrition Program for Women, Infants, and Children">WIC< /acronym>, or FoodShare< /li> < li>Trafficking FoodShare benefits< /li> < li>Crime, misconduct, and/or mismanagement by a DHS employee, official, or contractor< /li> < /ul> < p>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.< /p> < p>Wisconsin Stat. § < a href="http://docs.legis.wisconsin.gov/statutes/statutes/49/IV/49" target="_blank">49.49< /a> 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.< /p> < h2>Reporting Suspected Fraud and Abuse< /h2> < p>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.< /p> < p>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:< /p> < ul> < li>Going to the OIG fraud and abuse reporting < a href="https://www.reportfraud.wisconsin.gov/" target="_blank">website< /a>< /li> < li>Calling the DHS fraud and abuse hotline at 877-865-3432< /li> < /ul> < p>The following information is helpful when reporting fraud and abuse:< /p> < ul> < li>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.)< /li> < li>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< /li> < li>The names and date(s) of other people or agencies to which the activity may have been reported< /li> < /ul> < p>After the allegation is received, DHS OIG will evaluate it and take appropriate action. If the name and contact information of the person reporting the allegation was provided, the OIG may be in contact to verify details or ask for additional information.< /p>

Prescription

Topic #520

Disposable Medical Supplies and Durable Medical Equipment

All DME (durable medical equipment) and DMS (disposable medical supplies) require a physician or physician assistant prescription signed and dated by the prescriber except for the following DMS:

- Hearing instrument accessories
- Hearing instrument batteries
- Hearing instrument repairs

Prescribers are reminded that they are required to determine that all DME and DMS items are medically necessary before a prescription is written. More information about coverage and limitations is available under the DMS and DME service areas of this Online Handbook.

Breast Pumps

Wisconsin Medicaid reimburses for the prescribing of breast pumps as part of an E&M (evaluation and management) office visit. Physicians are required to document clinical requirements of an individual's need for a breast pump. Wisconsin Medicaid requires the following criteria be met:

- The member recently delivered a baby and a physician has ordered or recommended mother's breast milk for the infant.
- Documentation indicates there is the potential for adequate milk production.
- Documentation indicates there is a long-term need for and planned use of the breast pump to obtain a milk supply for the infant.
- The member is capable of being trained to use the breast pump as indicated by the physician or provider.
- Current or expected physical separation of mother and infant would make breastfeeding difficult (e.g., illness, hospitalization, work), or there is difficulty with "latch on" due to physical, emotional, or developmental problems of the mother or infant.

The optional Breast Pump Order (F-01153 (02/09)) form is to be completed by the provider, given to the provider of the breast pump, and kept in the member's medical record.

Physicians or nurse practitioners may prescribe breast pumps for members that can then be obtained through a Medicaid-enrolled DME provider or pharmacy. Wisconsin Medicaid does not reimburse prescribing providers for supplying breast pumps, unless they are also Medicaid-enrolled as a DME provider or a pharmacy.

Topic #525

General Requirements

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

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

Drug Enforcement Agency Number Audits

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

Members in Hospitals and Nursing Homes

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

Topic #523

Prescriber Information for Drug Prescriptions

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

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

- PDL (Preferred Drug List)
- PA (prior authorization)
- BBG (brand before generic) drugs that require PA
- BMN (brand medically necessary) drugs that require PA
- Diagnosis-restricted drugs
- Age-restricted 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 BadgerCare Plus, Medicaid, or SeniorCare, prescribers are encouraged to write prescriptions for preferred drugs. Prescribers are encouraged to prescribe more than one preferred drug before a non-preferred drug is prescribed.

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

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

Diagnosis-Restricted Drugs

Prescribers are required to include a diagnosis description on prescriptions for those drugs that are diagnosis-restricted.

Prescribing Drugs Manufactured by Companies Who Have Not Signed the Rebate Agreement

By federal law, pharmaceutical manufacturers who participate in state Medicaid programs must sign a rebate agreement with 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 BadgerCare Plus, Medicaid, or SeniorCare (Levels 1 and 2a)

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

Prescribers are required to complete the appropriate section(s) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) as it pertains to the drug being requested.

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

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

treat the member's medical condition

If a PA request for a drug without a signed manufacturer rebate is approved, claims for drugs without a signed rebate agreement must be submitted on paper. Providers should complete and submit the Noncompound Drug Claim (F-13072 (04/17)) form indicating the actual NDC of the drug with the Pharmacy Special Handling Request (F-13074 (04/14)) form.

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

Members Enrolled in SeniorCare (Levels 2b and 3)

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

Drug Utilization Review System

The federal OBRA (Omnibus Budget Reconciliation Act) of 1990 (42 C.F.R. Parts 456.703 and 456.705) called for a DUR (Drug Utilization Review) program for all Medicaid-covered drugs to improve the quality and cost-effectiveness of member care. ForwardHealth's prospective DUR system assists pharmacy providers in screening certain drug categories for clinically important potential drug therapy problems before the prescription is dispensed to the member. The DUR system checks the member's entire drug history regardless of where the drug was dispensed or by whom it was prescribed.

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

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

Prospective Drug Utilization Review's Impact on Prescribers

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

Drugs with Three-Month Supply Requirement

ForwardHealth has identified a list of three-month supply drugs:

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

Member Benefits

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

- Aiding compliance in taking prescribed generic, maintenance medications
- Reducing the cost of member copayments

- Requiring fewer trips to the pharmacy
- Allowing the member to obtain a larger quantity of generic, maintenance drugs for chronic conditions (e.g., hypertension)

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

Prescription Quantity

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

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

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

Prescription Mail Delivery

Current Wisconsin law permits 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.

Provider Enrollment

Topic #899

CLIA Certification or Waiver

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

CLIA Enrollment

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

CLIA Regulations

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

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

Scope of CLIA

CLIA governs all laboratory operations including the following:

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

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

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

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

CLIA Certification Types

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

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

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

Applying for CLIA Certification

Use the CMS 116 CLIA application to apply for program certificates. Providers may obtain CMS 116 forms from the CMS website or from the following address:

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

Providers Required to Report Changes

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

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

Wisconsin Medicaid
Provider Enrollment
313 Blettner Blvd
Madison WI 53784

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

Topic #3969

Categories of Enrollment

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

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

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

Billing/Rendering Provider

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

Rendering-Only Provider

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

Billing-Only Provider (Including Group Billing)

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

Group Billing

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

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

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

Topic #14137

Enrollment Requirements Due to the Affordable Care Act

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

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

Topic #194

In-State Emergency Providers and Out-of-State Providers

ForwardHealth requires all in-state emergency providers and out-of-state providers who render services to BadgerCare Plus, Medicaid, or SeniorCare members to be enrolled in Wisconsin Medicaid. Information is available regarding the enrollment options for in-state emergency providers and out-of-state providers.

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

Topic #193

Materials for New Providers

On an ongoing basis, providers should refer to the Online Handbook for the most current BadgerCare Plus, Medicaid, and ADAP (Wisconsin AIDS Drug Assistance Program) information. Future changes to policies and procedures are published in

ForwardHealth Updates.

Topic #1269

Nurse Midwives

Nurse midwives who treat BadgerCare Plus or Medicaid members are required to be Medicaid-enrolled to receive Medicaid reimbursement. This applies to nurse midwives whose services are reimbursed under a physician's or clinic's NPI (National Provider Identifier), as well as to those who independently submit claims to ForwardHealth.

A Master's degree-prepared nurse midwife is eligible to be Medicaid-enrolled as a nurse practitioner. Medicaid-enrolled nurse practitioners have a broader range of Medicaid-allowable services for which they may be reimbursed and receive higher reimbursement.

Nurse midwives who are not educated at the Master's degree level are Medicaid-enrolled as nurses in independent practice with a specialty of nurse midwife.

To be reimbursed by Wisconsin Medicaid, a nurse midwife must be enrolled under Wis. Admin. Code § DHS 105.201.

Medicaid services performed by nurse midwives must be within the legal scope of practice as defined under the Wisconsin Board of Nursing licensure or certification. Services performed must be included in the individual nurse midwife's protocols or under a collaborative relationship with a physician as defined by the Board of Nursing.

Protocols/Collaborative Agreements

Pursuant to Wis. Admin. Code § N 8.10(7), APNPs (advanced practice nurse prescribers) work in a collaborative relationship with a physician. A collaborative relationship means an APNP works "with a physician, in each other's presence when necessary, to deliver health care services within the scope of the practitioner's professional expertise." The APNP and the physician must document this relationship.

APNPs who dispense drugs in addition to prescribing them should obtain the appropriate pharmacy publications. Providers may also call Provider Services.

Medicaid-enrolled nurse midwives who are not APNPs practice in collaboration with a physician with postgraduate training in obstetrics and under a written agreement with that physician, pursuant to Wisconsin statute for the Board of Nursing, Wis. Stats § 441.15. Collaboration is defined here to mean "a process that involves two or more health care professionals working together and, when necessary, in each other's presence, and in which each health care professional contributes his or her expertise to provide more comprehensive care than one health care professional alone can offer."

For purposes of Medicaid reimbursement, no service that is a medical act and is listed in the Nurse Midwife service area or the Physician service area of the Online Handbook may be performed without a collaborative agreement as required for APNPs (pursuant to Wis. Admin. Code ch N 8.10,) or nurse midwives (pursuant to Wis. Admin. Code § 441.15), or protocols, written or verbal orders for registered nurses (pursuant to Wis. Admin. Code ch. N 6.03).

Topic #4457

Provider Addresses

ForwardHealth has the capability to store the following types of addresses and contact information:

- **Practice location address and related information.** This address is where the provider's office is physically located and

where records are normally kept. Additional information for the practice location includes the provider's office telephone number and the telephone number for members' use. With limited exceptions, the practice location and telephone number for members' use are published in a provider directory made available to the public.

- **Mailing address.** This address is where ForwardHealth will mail general information and correspondence. Providers should indicate accurate address information to aid in proper mail delivery.
- **PA (prior authorization) address.** This address is where ForwardHealth will mail PA information.
- **Financial addresses.** Two separate financial addresses are stored for ForwardHealth. The checks address is where ForwardHealth will mail paper checks. The 1099 mailing address is where ForwardHealth will mail IRS Form 1099.

Providers may submit additional address information or modify their current information using the demographic maintenance tool.

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

Topic #14157

Provider Enrollment Information Home Page

ForwardHealth has consolidated all information providers will need for the enrollment process in one location on the ForwardHealth Portal. For information related to enrollment criteria and to complete online provider enrollment applications, providers should refer to the Provider Enrollment Information home page.

The Provider Enrollment Information home page includes enrollment applications for each provider type and specialty eligible for enrollment with Wisconsin Medicaid. Prior to enrolling, providers may consult a provider enrollment criteria menu, which is a reference for each individual provider type detailing the information the provider may need to gather before beginning the enrollment process, including:

- Links to enrollment criteria for each provider type
- Provider terms of reimbursement
- Disclosure information
- Category of enrollment
- Additional documents needed (when applicable)

Providers will also have access to a list of links related to the enrollment process, including:

- General enrollment information
- Regulations and forms
- Provider type-specific enrollment information
- In-state and out-of-state emergency enrollment information
- Contact information

Information regarding enrollment policy and billing instructions may still be found in the Online Handbook.

Topic #1931

Provider Type and Specialty Changes

Provider Type

Providers who want to add a provider type or change their current provider type are required to complete a new enrollment application for each provider type they want to add or change to because they need to meet the enrollment criteria for each provider type.

Provider Specialty

Providers who have the option to add or change a provider specialty can do so using the demographic maintenance tool. After adding or changing a specialty, providers may be required to submit documentation to ForwardHealth, either by uploading through the demographic maintenance tool or by mail, supporting the addition or change.

Providers should contact Provider Services with any questions about adding or changing a specialty.

Topic #14317

Terminology to Know for Provider Enrollment

Due to the ACA (Affordable Care Act), ForwardHealth has adopted new terminology. The following table includes new terminology that will be useful to providers during the provider enrollment and revalidation processes. Providers may refer to the Medicaid rule 42 C.F.R. s. 455.101 for more information.

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

Person with an ownership or control interest	A person or corporation for which one or more of the following applies: - Has an ownership interest totaling five percent or more in a disclosing entity - Has an indirect ownership interest equal to five percent or more in a disclosing entity - Has a combination of direct and indirect ownership interest equal to five percent or more in a disclosing entity - Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or asset of the disclosing entity - Is an officer or director of a disclosing entity that is organized as a corporation - Is a person in a disclosing entity that is organized as a partnership
Subcontractor	- An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or, - An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.
Re-enrollment	Re-enrollment of a provider whose Medicaid enrollment has ended for any reason other than sanctions or failure to revalidate may be re-enrolled as long as all licensure and enrollment requirements are met. Providers should note that when they re-enroll, application fees and screening activities may apply. Re-enrollment was formerly known as re-instate.
Revalidation	All enrolled providers are required to revalidate their enrollment information every three years to continue their participation with Wisconsin Medicaid. Revalidation was formerly known as recertification.

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

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 website. The federal CMS (Centers for Medicare and Medicaid Services) website includes more information on Type 1 and Type 2 NPIs.

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

Non-healthcare Providers

Non-healthcare providers, such as SMV (specialized medical vehicle) providers, personal care agencies, and blood banks, are exempt from federal NPI requirements. Providers exempt from federal NPI requirements are assigned a Medicaid provider number once their enrollment application is accepted; they are required to indicate this Medicaid provider number on electronic and paper transactions submitted to ForwardHealth.

Topic #5096

Taxonomy Codes

Taxonomy codes are standard code sets used to provide information about provider type and specialty for the provider's enrollment. ForwardHealth uses taxonomy codes as additional data for correctly matching the NPI (National Provider Identifier) to the provider file.

Providers are required to use a taxonomy code when the NPI reported to ForwardHealth corresponds to multiple enrollments and the provider's practice location ZIP+4 code does not uniquely identify the provider.

Providers are allowed to report multiple taxonomy codes to ForwardHealth as long as the codes accurately describe the provider type and specialty for the provider's enrollment. When doing business with ForwardHealth, providers may use any one of the reported codes. Providers who report multiple taxonomy codes will be required to designate one of the codes as the primary taxonomy code; ForwardHealth will use this primary code for identification purposes.

Providers who wish to change their taxonomy code or add additional taxonomy codes may do so using the demographic maintenance tool. Most taxonomy code changes entered through the demographic maintenance tool will take effect in real time; providers may use the new codes immediately on transactions.

Omission of a taxonomy code when it is required as additional data to identify the provider will cause claims and other transactions to be denied or delayed in processing.

Note: Taxonomy codes do not change provider enrollment or affect reimbursement terms.

Topic #5097

ZIP Code

The ZIP code of a provider's practice location address on file with ForwardHealth must be a ZIP+4 code. The ZIP+4 code helps to identify a provider when the NPI (National Provider Identifier) reported to ForwardHealth corresponds to multiple enrollments and the reported taxonomy code does not uniquely identify the provider.

When a ZIP+4 code is required to identify a provider, omission of it will cause claims and other transactions to be denied or delayed in processing.

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

Provider Rights

Topic #208

A Comprehensive Overview of Provider Rights

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

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

Topic #207

Ending Participation

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

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

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

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

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

Wisconsin Medicaid
Provider Enrollment
313 Blettner Blvd
Madison WI 53784

If the provider fails to specify an effective date in the notice of termination, ForwardHealth may terminate the provider on the date the notice is received.

Topic #209

Hearing Requests

A provider who wishes to contest a Wisconsin DHS (Department of Health Services) action or inaction for which due process is

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

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

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

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

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

Topic #210

Limiting the Number of Members

If providers choose to limit the number of members they see, they cannot accept a member as a private-pay patient. Providers should instead refer the member to another ForwardHealth provider.

Persons applying for or receiving benefits are protected against discrimination based on race, color, national origin, sex, religion, age, disability, or association with a person with a disability.

Topic #206

Requesting Discretionary Waivers and Variances

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

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

Requirements

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

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

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

Application

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

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

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

Division of Medicaid Services
Waivers and Variances
PO Box 309
Madison WI 53701-0309

Sanctions

Topic #211

Intermediate Sanctions

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

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

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

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

Topic #212

Involuntary Termination

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

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

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

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

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

Topic #213

Sanctions for Collecting Payment From Members

Under state and federal laws, if a provider inappropriately collects payment from an enrolled member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid enrollment. In addition, the provider may also be fined not more than $25,000, or imprisoned not more than five years, or both, pursuant to 42 USC § 1320a-7b(d) or Wis. Stat. § 49.49(3m).

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

Topic #214

Withholding Payments

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

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

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

Reimbursement

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Archive Date:03/02/2020

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, Medicaid, or ADAP (Wisconsin AIDS Drug Assistance Program)) may not exceed the allowed amount. As a result, providers may not collect payment from a member, or authorized person acting on behalf of the member, for the difference between their usual and customary charge and the allowed amount for a service (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, Medicaid, or ADAP.

Topic #8277

Additional Reimbursement for Reporting Body Mass Index

ForwardHealth is collecting BMI (body mass index) data on children enrolled in BadgerCare Plus or Medicaid to gather baseline information for future policy initiatives.

ForwardHealth will reimburse an additional $10.00 to providers and clinics for reporting BMI on professional claims for routine office visits and preventive services for members two to 18 years old on the DOS.

Providers who are eligible to receive the additional reimbursement include the following:

- HealthCheck agencies
- Nurse midwives
- Nurse practitioners
- Physician assistants
- Physicians

Reporting Body Mass Index on Claims

For the additional reimbursement, CPT (Current Procedural Terminology) Category II procedure code 3008F (Body mass index, documented) is required on the claim in addition to an office visit procedure code. An ICD diagnosis reporting the pediatric BMI outcome must be associated with code 3008F. A $10.00 minimum is required to be billed for procedure code 3008F.

Providers are required to maintain records that fully document the basis of charges upon which all claims for additional reimbursement payments are made.

Reimbursement

Providers are paid $10.00 per billing provider, per child, per calendar year for reporting BMI for members in fee-for-service.

Payments for reporting BMI will appear on the RA (Remittance Advice) under EOB (Explanation of Benefits) code 9944, "Pricing Adjustment - Incentive Pricing."

Topic #694

Billing Service and Clearinghouse Contracts

According to Wis. Admin. Code § DHS 106.03(5)(c)2, 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 #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 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 #897

Fee Schedules

Maximum allowable fee information is available on the ForwardHealth Portal in the following forms:

- Interactive fee schedule
- Downloadable fee schedule in TXT (text) files

Certain fee schedules are interactive. Interactive fee schedules provide coverage information as well as maximum allowable fees for all reimbursable procedure codes. The downloadable TXT files are free of charge and provide basic maximum allowable fee information for BadgerCare Plus by provider service area.

A provider may request a paper copy of a fee schedule by calling Provider Services.

Providers may call Provider Services in the following cases:

- Internet access is not available.
- There is uncertainty as to which fee schedule should be used.
- The appropriate fee schedule cannot be found on the Portal.
- To determine coverage or maximum allowable fee of procedure codes not appearing on a fee schedule.

Topic #648

Health Professional Shortage Areas

Enhanced reimbursement is provided to Medicaid-enrolled primary care providers and emergency medicine providers for

selected services when one or both of the following apply:

- The rendering or billing provider is located in a HPSA (Health Professional Shortage Area)-eligible ZIP code.
- The member has a residential address (according to enrollment records) within a HPSA-eligible ZIP code.

Primary care providers and emergency medicine providers include the following:

- Physicians with specialties of general practice, obstetrics and gynecology, family practice, internal medicine, or pediatrics
- Physician assistants
- Nurse practitioners
- Nurse midwives

Standard enhanced reimbursement for HPSA-eligible primary care procedures is an additional 20 percent of the physician maximum allowable fee. The enhanced reimbursement for HPSA-eligible obstetrical procedures is an additional 50 percent of the physician maximum allowable fee.

Health Professional Shortage Area-Eligible Procedure Codes

Providers may use HPSA modifier AQ (Physician providing a service in a HPSA) with the following categories of procedure codes (while the AQ modifier is defined for physicians only, any Medicaid HPSA-eligible provider may use the modifier when appropriate):

- E&M (evaluation and management)Office Visits, New Patient
- E&M Office Visits, Established Patient
- E&M Home Visits, New Patient
- E&M Home Visits, Established Patient
- Emergency Department Services
- Newborn Care
- Preventive Medicine
- Obstetric Care
- Vaccines

Use of Modifier AQ

To obtain the HPSA-enhanced reimbursement, providers are required to indicate modifier AQ along with the appropriate procedure code on the claim. (Refer to the Pediatric Services Performed in a Health Professional Shortage Area section of this topic for information regarding use of modifier AQ for pediatric services.)

Medicare Crossover Claims

Medicare HPSA policy differs from Wisconsin Medicaid's HPSA policy in many ways. Medicaid covers more services than **Medicare**, allows a broader range of providers to receive the incentive payment, pays a higher bonus, and defines HPSA differently than **Medicare**. Most importantly, Wisconsin Medicaid pays the enhanced reimbursement to physicians, physician assistants, nurse practitioners, and nurse midwives while **Medicare** pays the HPSA incentive payment only to physicians.

For these reasons, Medicare crossover claims that are eligible for the Medicaid HPSA incentive payment may not automatically be forwarded to ForwardHealth from **Medicare**. Providers may have to submit these claims directly to ForwardHealth.

Antepartum Care Visits Performed in a Health Professional Shortage Area

If a provider renders three or fewer antepartum care visits, the provider is required to bill the appropriate E&M service code with modifier TH (Obstetrical treatment/services, prenatal or postpartum) listed first and the HPSA modifier AQ listed second.

If a provider renders three or fewer antepartum care visits and the rendering provider is a licensed midwife, the provider is required to bill procedure code 59425 with modifier 52 (representing antepartum care only; less than 4 visits) listed first and the HPSA modifier AQ listed second.

Pediatric Services Performed in a Health Professional Shortage Area

Pediatric services include office and other outpatient services and emergency department services for members 18 years of age and younger.

Reimbursement for eligible procedure codes with HPSA modifier AQ automatically includes the pediatric incentive payment, when applicable, since the incentive payment is based on the age of the member. Providers should not submit claims with modifier TJ in addition to HPSA modifier AQ for the same procedure code. Providers should *only* include the HPSA modifier in situations where both of these modifiers apply. Wisconsin Medicaid will determine the member's age and determine the proper HPSA reimbursement for these procedure codes.

Modifier TJ may be used when submitting claims for eligible services in situations that do not qualify for HPSA-enhanced reimbursement.

HealthCheck Services Not Eligible for Health Professional Shortage Area Incentive Payment

Procedure codes 99381-99385 and 99391-99395 are **not** eligible for HPSA incentive payments, regardless of the billing or rendering provider's or member's location, since reimbursement for these procedure codes includes enhanced reimbursement for HealthCheck services.

Claims Submitted Inappropriately for Health Professional Shortage Area Incentive Payment

Providers who submit claims for the HPSA-enhanced reimbursement inappropriately are reimbursed the lesser of the provider's usual and customary fee or the maximum allowable fee, assuming that all other ForwardHealth policies are followed. The enhanced reimbursement amount is not paid when the HPSA modifier is submitted but the provider or member is not eligible for HPSA designation.

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 #260

Maximum Allowable Fees

Maximum allowable fees are established for most covered services. Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

Providers are reimbursed at the lesser of their billed amount and the maximum allowable fee for the procedure.

Topic #1246

Wisconsin Medicaid reimburses nurse midwives 100 percent of the physician maximum allowable fee for laboratory services and injections and 90 percent of the physician maximum allowable fee for other physician services.

Topic #649

Maximum Daily Reimbursement

ForwardHealth reimbursement for services performed on the same DOS (date of service) for the same member by the same rendering provider is limited to $2,331.37 for services rendered by the following providers:

- Anesthesiologists
- Anesthesiologist Assistants
- Certified Registered Nurse Anesthetists
- Dentists
- Licensed midwives
- Nurse Midwives
- Nurse Practitioners
- Oral Surgeons
- Physician Assistants
- Physicians
- Podiatrists

The maximum daily reimbursement amount does not apply to physician-administered drugs and DME (durable medical equipment).

ForwardHealth remittance information will indicate when the maximum daily reimbursement amount has been met.

Requests to Exceed Maximum Daily Reimbursement Limit

Providers may request additional reimbursement to exceed the maximum daily reimbursement limit when both of the following criteria are met:

1. A surgery exceeds 6 hours or anesthesia exceeds 7.5 hours.
2. The Medicaid-allowed amount for the services meets or exceeds the maximum daily reimbursement limit.

Submitting Supporting Documentation

To request reimbursement in excess of the maximum daily reimbursement limit, providers are required to submit the following information on the claim:

- In the Notes field, indicate "request for additional reimbursement for surgery in excess of 6 hours," or "request for additional reimbursement for anesthesia services in excess of 7.5 hours."
- Attach supporting documentation to the claim that clearly indicates the length of the surgery or the length of the anesthesia services, such as a post-operative report.

Providers are reminded of the following options for providing supporting documentation along with a claim:

- On paper with supporting documentation submitted on paper.
- Electronically using DDE (Direct Data Entry) through the Portal, PES (Provider Electronic Solutions) transactions, or 837 Health Care Claim electronic transactions. For more information, refer to the User Guides page of the ForwardHealth Portal.
- Electronically with an indication that supporting documentation will be submitted separately on paper. For more information, refer to the ForwardHealth Companion Guides.

Topic #1245

Pediatric Services

Wisconsin Medicaid provides an enhanced reimbursement rate for office and other outpatient services (CPT (Current Procedural Terminology) codes 99201-99215) and emergency department services (CPT codes 99281-99285) for members 18 years of age and under. The enhanced reimbursement rates are indicated on the nurse midwife maximum allowable fee schedule.

To obtain the enhanced reimbursement for members under 18 years old, indicate the applicable procedure code and modifier "TJ" (Program group, child and/or adolescent) on the claim.

Collecting Payment From Members

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 #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.
- Other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) payments made to the member.
- Spenddown.
- Charges for a private room in a nursing home if meeting the requirements stated in Wis. Admin. Code § DHS 107.09(4)(k), or in a hospital if meeting the requirements stated in Wis. Admin. Code § DHS 107.08(3)(a)2.
- 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.

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 and Medicare Cost plans
- 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 is the payer of last resort for any covered services. Therefore, the provider is required to make a reasonable effort to exhaust all other existing health insurance sources before submitting claims to ForwardHealth or to a state-contracted MCO (managed care organization).

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 #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:03/02/2020

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 ForwardHealth Portal (information about claims, enrollment verification, and PA (prior authorization) requests on the Portal). Refer to the Providers Trainings page for the latest information on training opportunities.

Additional Inquiries

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

- Claims, including discrepancies regarding enrollment verification and claim processing
- PES (Provider Electronic Solutions) claims submission software
- Claims processing problems that have not been resolved through other channels (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 email, 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 their 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 (date of service)
- Amount billed
- RA (Remittance Advice)
- Procedure code of the service in question
- Reference to any provider publications that address the inquiry

Call Center 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 (e.g., Medicaid, WCDP, or WWWP) or to the service area (e.g., 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:

- Member enrollment — for member enrollment inquiries and verification
- Claim and PA status — for claim and PA status inquiries
- Pharmacy — for drug claim, policy, and drug authorization inquiries
- Dental — for dental inquiries
- Policy — for all policy questions except those for pharmacy and dental
- Provider enrollment — for provider enrollment and revalidation questions
- EHR (Electronic Health Record) — for EHR inquiries

Walk-in Appointments

Walk-in appointments offer face-to-face assistance for providers at the Provider Services office. Providers must schedule an appointment in advance by contacting Provider Services at 800-947-9627. Appointments for in-person provider assistance are available Monday through Friday, 7:30 a.m.-4:00 p.m. (CST), except for state-observed holidays. Providers without an appointment may not receive in-person assistance and may have to schedule an appointment for a later date.

Written Inquiries

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

Providers may submit written inquiries to ForwardHealth by mail using the Written Correspondence Inquiry (F-01170 (07/12))

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 DMS (Division of Medicaid Services) 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-01016 (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 Reference Guide

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

ForwardHealth Portal	***www.forwardhealth.wi.gov/***	**24 hours a day, seven days a week**
Public and secure access to ForwardHealth information with direct link to contact Provider Services for up-to-date access to ForwardHealth programs information, including publications, fee schedules, and forms.		
WiCall Automated Voice Response System	**(800) 947-3544**	**24 hours a day, seven days a week**
WiCall, the ForwardHealth Automated Voice Response system, provides responses to the following inquiries: • Checkwrite. • Claim status. • Prior authorization. • Member enrollment.		
ForwardHealth Provider Services Call Center	**(800) 947-9627**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Standard Time)***
To assist providers in the following programs: • BadgerCare Plus. • Medicaid. • SeniorCare. • Wisconsin Well Woman Medicaid. • Wisconsin Chronic Disease Program (WCDP). • Wisconsin Well Woman Program (WWWP). • Wisconsin Medicaid and BadgerCare Plus Managed Care Programs.		
ForwardHealth Portal Helpdesk	**(866) 908-1363**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Standard Time)***
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal accounts, registrations, passwords, and submissions through the Portal.		
Electronic Data Interchange Helpdesk	**(866) 416-4979**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Standard Time)***
For providers, trading partners, billing services, and clearinghouses with technical questions about the following: • Electronic transactions. • Companion documents. • Provider Electronic Solutions (PES) software.		
Managed Care Provider Appeals	**(800) 760-0001, Option 1**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Standard Time)***
To assist BagderCare Plus and Medicaid Supplemental Security Income (SSI) managed care providers with questions regarding their appeal status and other general managed care provider appeal information.		
Managed Care Ombudsman Program	**(800) 760-0001**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Standard Time)***
To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.		
Member Services	**(800) 362-3002**	**Monday through Friday, 8:00 a.m. to 6:00 p.m. (Central Standard Time)***
To assist ForwardHealth members or persons calling on behalf of members with program information and requirements, enrollment, finding certified providers, and resolving concerns.		
Wisconsin AIDS Drug Assistance Program (ADAP)	**(800) 991-5532**	**Monday through Friday, 8:00 a.m. to 4:30 p.m.**

		(Central Standard Time)*
To assist ADAP providers and members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		

*With the exception of state-observed holidays.

Electronic Data Interchange

Topic #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, ADAP (Wisconsin AIDS Drug Assistance Program), 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 email 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 Eligibility & Benefit Inquiry and 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, ADAP (Wisconsin AIDS Drug Assistance Program), 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 Eligibility & Benefit Inquiry and 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 Acknowledgment for Health Care Insurance). 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 Acknowledgment for Health Care Insurance) 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 health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) 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.

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 their 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 they are not enrolled; therefore, it is essential that providers verify enrollment before providing services. To reduce claim denials, it is important that providers verify the following information prior to each DOS (date of service) that services are provided:

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

Topic #4898

Responses Are Based on Financial Payer

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

There are three financial payers under ForwardHealth:

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

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

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 website. 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 website 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 their 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 their organization and assign security roles to clerks that have been established. To establish an administrative account after receiving a PIN, the administrative user is required to follow these steps:

1. Go to the ForwardHealth Portal.
2. Click the **Providers** button.
3. Click **Logging in for the first time?**.
4. Enter the Login ID and PIN. The Login ID is the provider's NPI (National Provider Identifier) or provider number.
5. Click **Setup Account**.
6. At the Account Setup screen, enter the user's information in the required fields.

7. Read the security agreement and click the checkbox to indicate agreement with its contents.
8. Click **Submit** when complete.

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

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

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

Topic #16737

Demographic Maintenance Tool

The demographic maintenance tool allows providers to update information online that they are required to keep current with ForwardHealth. To access the demographic maintenance tool, providers need a ForwardHealth Portal account. After logging into their Portal account, providers should select the Demographic Maintenance link located in the Home Page box on the right side of the secure Provider home page.

Note: The Demographic Maintenance link will only display for administrative accounts or for clerk accounts that have been assigned the Demographic Maintenance role. The Account User Guide provides specific information about assigning roles.

The demographic maintenance tool contains general panels which are available to all or most providers as well as specific panels which are only available to certain provider types and specialties. The Demographic Maintenance Tool User Guide provides further information about general and provider-specific panels.

Uploading Supporting Documentation

Providers can upload enrollment-related supporting documentation (e.g., licenses, certifications) using the demographic maintenance tool. Documents in the following formats can be uploaded:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg)
- PDF (Portable Document Format) (.pdf)

To avoid delays in processing, ForwardHealth strongly encourages providers to upload their documents.

Submitting Information

After making **all** their changes, providers are required to submit their information in order to save it. After submitting information, providers will receive one of the following messages:

- "Your information was **updated** successfully." This message indicates that providers' files were immediately updated with the changed information.
- "Your information was **uploaded** successfully." This message indicates that ForwardHealth needs to verify the information before providers' files can be updated. Additionally, an Application Submitted panel will display and indicate next steps.

Verification

ForwardHealth will verify changes within 10 business days of submission. If the changes can be verified, ForwardHealth will update providers' files. In some cases, providers may receive a Change Notification letter indicating what information ForwardHealth updated. Providers should carefully review the Provider File Information Change Summary included with the letter to verify the accuracy of the changes. If any of the changes are inaccurate, providers can correct the information using the demographic maintenance tool. Providers may contact Provider Services if they have questions regarding the letter.

Regardless of whether or not providers are notified that their provider files were updated, changed information is not considered approved until 10 business days after the information was changed. If the changes cannot be verified within 10 business days, ForwardHealth will notify providers by mail that their provider files were not updated, and providers will need to make corrections using the demographic maintenance tool.

Topic #4340

Designating a Trading Partner to Receive 835 Health Care Claim Payment/Advice Transactions

Providers must designate a trading partner to receive their 835 (835 Health Care Claim Payment/Advice) transaction for ForwardHealth interChange.

Providers who wish to submit their 835 designation via the Portal are required to create and establish a provider account to have access to the secure area of the Portal.

To designate a trading partner to receive 835 transactions, providers must first complete the following steps:

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

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

Topic #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 #4581

HealthCheck Information Available Through the ForwardHealth Portal

HealthCheck providers can access outreach reports and view screening history, the periodicity schedule, and the WIR (Wisconsin Immunization Registry) through the ForwardHealth Portal.

HealthCheck Agency Portal Outreach Reports

HealthCheck agency outreach reports are available through the secure area of the Portal for agencies with "active" Portal user IDs. HealthCheck outreach agencies receive a notification in their message box when updated monthly and quarterly reports are available. The message gives providers instructions on how to download their files. Notifications in the message box are retained for seven calendar days.

The monthly report, titled "HealthCheck Monthly Screening," is uploaded every 28 days and the quarterly report, titled "HealthCheck Quarterly Eligibility Member," is replaced every 88 days by a new report with updated information.

Paper reports are mailed to providers without a Portal account.

HealthCheck Screening Inquiry

Providers may use the online inquiry function to query a member's HealthCheck screening history by entering one of the following:

- Member ID
- Member's first and last name and date of birth
- Member Social Security number and date of birth

Once the member information is entered, the following member information is displayed:

- Member ID
- First and last name
- Date of last HealthCheck screening
- Date of last HealthCheck dental screening
- Date of birth

If the member has additional past HealthCheck medical screenings or HealthCheck dental screenings, the history of the member is displayed in the "Search Results" panel including:

- Previous date(s) of service
- Name(s) of provider(s) that performed past HealthCheck medical or dental screening(s)
- Member age at time of previous HealthCheck medical or dental screening(s)
- Status of the claim(s)

Information about HealthCheck screens reimbursed by fee-for-service or HMOs (health maintenance organizations) is available through the HealthCheck screening inquiry.

Note: Providers have 365 days from the date of service to submit a claim, and HMOs have one year to submit encounter data. Therefore, delayed submission of HealthCheck screening information affects the availability of data in the screening query.

Periodicity Schedule

The periodicity schedule lists the frequency and timing of recommended HealthCheck screens. Providers may also access the periodicity schedule via the HealthCheck provider resource page in the Provider area of the Portal.

WIR

A link on the secure HealthCheck page in the Portal connects users to the WIR website to view immunization data. WIR will continue to monitor all vaccination information for children, maintain recommended immunization schedules, record immunizations, track contraindications and reactions, and verify immunization history. Additionally, complete blood lead level testing history and the testing results are available.

Providers may access the WIR website via the Portal or may continue to access the site directly at *https://www.dhfswir.org/*. Login and password requirements for WIR apply regardless of the link used to reach the website.

Topic #4451

Inquiries to ForwardHealth Via the Portal

Providers are able to contact Provider Services through the ForwardHealth Portal by clicking the Contact link and entering the relevant inquiry information, including selecting the preferred method of response (i.e., telephone call or email). Provider Services will respond to the inquiry by the preferred method of response indicated within five business days.

Topic #4400

Internet Connection Speed

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

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

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

Topic #4351

Logging in to the Provider Area of the Portal

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

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 login is required to access the secure area of the Portal to submit or retrieve account and member information that may be sensitive.

The following information is available through the Portal:

- Listing of all Medicaid-enrolled providers
- Coordination of Benefits Extract/Insurance Carrier Master List information updated quarterly
- Data Warehouse, which is linked from the Portal to Business Objects. The Business Objects function allows for access to MCO data for long-term care MCOs.
- Electronic messages
- Enrollment verification by entering a member ID or SSN (Social Security number) with date of birth and a "from DOS (date of service)" and a "to DOS" range. A transaction number is assigned to track the request.
- Member search function for retrieving member information such as medical status codes and managed care and Medicare information
- Provider search function for retrieving provider information such as the address, 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 gives providers access to all policy and billing information for Wisconsin Medicaid, BadgerCare Plus, ADAP (Wisconsin AIDS Drug Assistance Program), and WCDP (Wisconsin Chronic Disease Program). A secure ForwardHealth Portal account is not required to use the Online Handbook, as it is available to all Portal visitors.

Revisions to Online Handbook information are incorporated after policy changes have been issued in *ForwardHealth Updates*, typically on the policy effective date. The Online Handbook also links to the Communication Home page, which takes users to

ForwardHealth Updates, user guides, and other communication pages.

The Online Handbook 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
- Covered and Noncovered Services
- 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 **Online Handbooks** under the Policy and Communication heading.
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 searching 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 **Search**.

ForwardHealth Publications Archive Area

The Handbook Archives page allows providers to view 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 **Communication Home** link under the Policy and Communication heading.
3. Click the **Online Handbooks** link on the left sidebar menu.
4. Click on the **ForwardHealth Handbook Archives** link at the bottom of the page.

Topic #5089

Other Business Enhancements Available on the Portal

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

- Verify member enrollment.
- View RAs (Remittance Advice).

- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice).
- Update and maintain provider file information. Providers have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT (electronic funds transfer).
- Track provider-submitted PA (prior authorization) requests.

Topic #4911

Portal Account Administrators

Portal administrators are responsible for requesting, creating, and managing accounts to access these features for their organization.

There must be one administrator assigned for each Portal account and all users established for that account. The responsibilities of the Portal administrator include:

- Ensuring the security and integrity of all user accounts (clerk administrators and clerks) created and associated with their Portal account.
- Ensuring clerks or clerk administrators are given the appropriate authorizations they need to perform their functions for the provider, trading partner, or MCO (managed care organization).
- Ensuring that clerks or clerk administrator accounts are removed/deleted promptly when the user leaves the organization.
- Ensuring that the transactions submitted are valid and recognized by ForwardHealth.
- Ensuring that all users they establish know and follow security and guidelines as required by HIPAA (Health Insurance Portability Accountability Act of 1996). As Portal administrators establish their Portal account and create accounts for others to access private information, administrators are reminded that all users must comply with HIPAA. The HIPAA privacy and security rules require that the confidentiality, integrity, and availability of PHI (protected health information) are maintained at all times. The HIPAA Privacy Rule provides guidelines governing the disclosure of PHI. The HIPAA Security Rule delineates the security measures to be implemented for the protection of electronic PHI. If Portal administrators have any questions concerning the protection of PHI, visit the Portal for additional information.

Portal administrators have access to all secure functions for their Portal account.

Establish an Administrator Account

All Portal accounts require an administrator account. The administrator is a selected individual who has overall responsibility for management of the account. Therefore, they have complete access to all functions within the specific secure area of their Portal and are permitted to add, remove, and manage other individual roles.

Topic #4912

Portal Clerk Administrators

A Portal administrator may choose to delegate some of the authority and responsibility for setting up and managing the users within their ForwardHealth Portal account. If so, the Portal administrator may establish a clerk administrator. An administrator or clerk administrator can create, modify, manage or remove clerks for a Portal account. When a clerk is created, the administrator or clerk administrator must grant permissions to the clerks to ensure they have the appropriate access to the functions they will perform. A clerk administrator can only grant permissions that they themselves have. For example, if an administrator gives a clerk administrator permission only for enrollment verification, then the clerk administrator can only establish clerks with enrollment verification permissions.

Even if a Portal administrator chooses to create a clerk administrator and delegate the ability to add, modify, and remove users from the same account, the Portal administrator is still responsible for ensuring the integrity and security of the Portal account.

Topic #4913

Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their ForwardHealth Portal account. Clerks may be assigned one or many roles (i.e., claims, PA (prior authorization), member enrollment verification). Clerks do not have the ability to establish, modify, or remove other accounts.

Once a clerk account is set up, the clerk account does not have to be established again for a separate Portal account. Clerks can easily be assigned a role for different Portal accounts (i.e., different ForwardHealth enrollments). To perform work under a different Portal account for which they have been granted authorization, a clerk can use the "switch org" function and toggle between the Portal accounts to which they have access. Clerks may be granted different authorization in each Portal account (i.e., they may do member enrollment verification for one Portal account, and HealthCheck inquires for another).

Topic #4740

Public Area of the Provider Portal

The public Provider area of the ForwardHealth Portal offers a variety of important business features and functions that will assist in daily business activities with ForwardHealth programs.

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.

ForwardHealth Communications

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

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

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

Training

Providers can register for all scheduled trainings and view online trainings via the 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 email) the provider wishes to receive back from Provider Services. Provider Services will respond to the inquiry within five business days. Information will be submitted via a secure connection.

Online Enrollment

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

Other Resources Available on the Portal

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

- A "What's New?" section for providers that links to the latest information posted to the Provider area of the Portal.
- Home page for the provider. Providers have administrative control over their Portal homepage and can grant other employees access to specified areas of the Portal, such as claims and PA (prior authorization).
- Email subscription service for *Updates*. Providers can register for email subscription to receive notifications of new provider publications via email. Users are able to select, by program and service area, which publication notifications they would like to receive.
- A forms library.

Topic #4741

Secure Area of the Provider Portal

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

Claims and Adjustments Using the Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, and determine what claims are in "pay" status on the Portal. Providers 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 PA and Amendment Requests Via the Portal

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

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

- View the latest provider review and decision letters
- Receive messages about PA and amendment requests that have been adjudicated or returned for provider review

Electronic Communications

The secure Portal contains a 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 other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans), such as Medicare or commercial health insurance

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

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

Other Business Enhancements Available on the Portal

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

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

Topic #4401

System and Browser Requirements

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

Recommended System Requirements	Recommended Browser Requirements
Windows-Based Systems	

Computer with at least a 500Mhz processor, 256 MB of RAM, and 100MB of free disk space	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 Partners area of the ForwardHealth Portal:

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

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

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

Training Opportunities

Topic #12757

Training Opportunities

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

On-Site Sessions

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

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

Online (Real-Time, Web-Based) Sessions

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

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

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

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

Recorded Webcasts

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

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

Notification of Training Opportunities

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

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

Updates

Topic #478

Accessing ForwardHealth Communications

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

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

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

Topic #4458

Electronic Notifications from ForwardHealth

ForwardHealth sends electronic messaging via Portal Account messaging and e-mail subscription messaging to notify of newly released *ForwardHealth Updates*. ForwardHealth also uses electronic messaging to communicate training opportunities and other timely information. Providers who have established a ForwardHealth Portal account automatically receive notifications from ForwardHealth in their Portal Messages inbox. Providers and other interested parties may register to receive e-mail subscription notifications.

E-mail Subscription

When registering for e-mail subscription, providers and other interested parties are able to select, by program (Wisconsin Medicaid, BadgerCare Plus, ADAP (Wisconsin AIDS Drug Assistance Program), or WCDP (Wisconsin Chronic Disease Program)), provider type (e.g., physician, hospital, DME (durable medical equipment) vendor), and/or specific information of interest, (Trading Partner and ICD-10 (International Classification of Diseases, 10th Revision) Project Information) to designate what information they would like to receive. Any number of staff or other interested parties from an organization may sign up for an e-mail subscription and may select multiple subscription options.

Registering for E-mail Subscription

Users may sign up for an e-mail subscription by following these steps:

1. Click the Register for E-mail Subscription link on the ForwardHealth Portal home page.
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.

The selected subscriptions will load and a confirmation message will appear at the top of the page.

Topic #4460

Full Text Publications Available

Providers without internet access may call Provider Services to request that a paper copy of a *ForwardHealth Update* be mailed to them. To expedite the call, correspondents will ask providers for the *Update* number. Providers should allow seven to 10 business days for delivery.

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 member ID, if available, that exists on the DOS or within the DOS range selected will be listed.
- Commercial health 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
  - Request enrollment information for the same member using a different financial payer
  - Hear another member's enrollment information using the same financial payer
  - Hear another member's enrollment information using a different financial payer
  - 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 financial payer (program, i.e., Wisconsin Medicaid, WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)) and entering their provider ID, member identification number, DOS (date of service), and the amount billed.

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

Enrollment Verification

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

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

PA Status

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

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

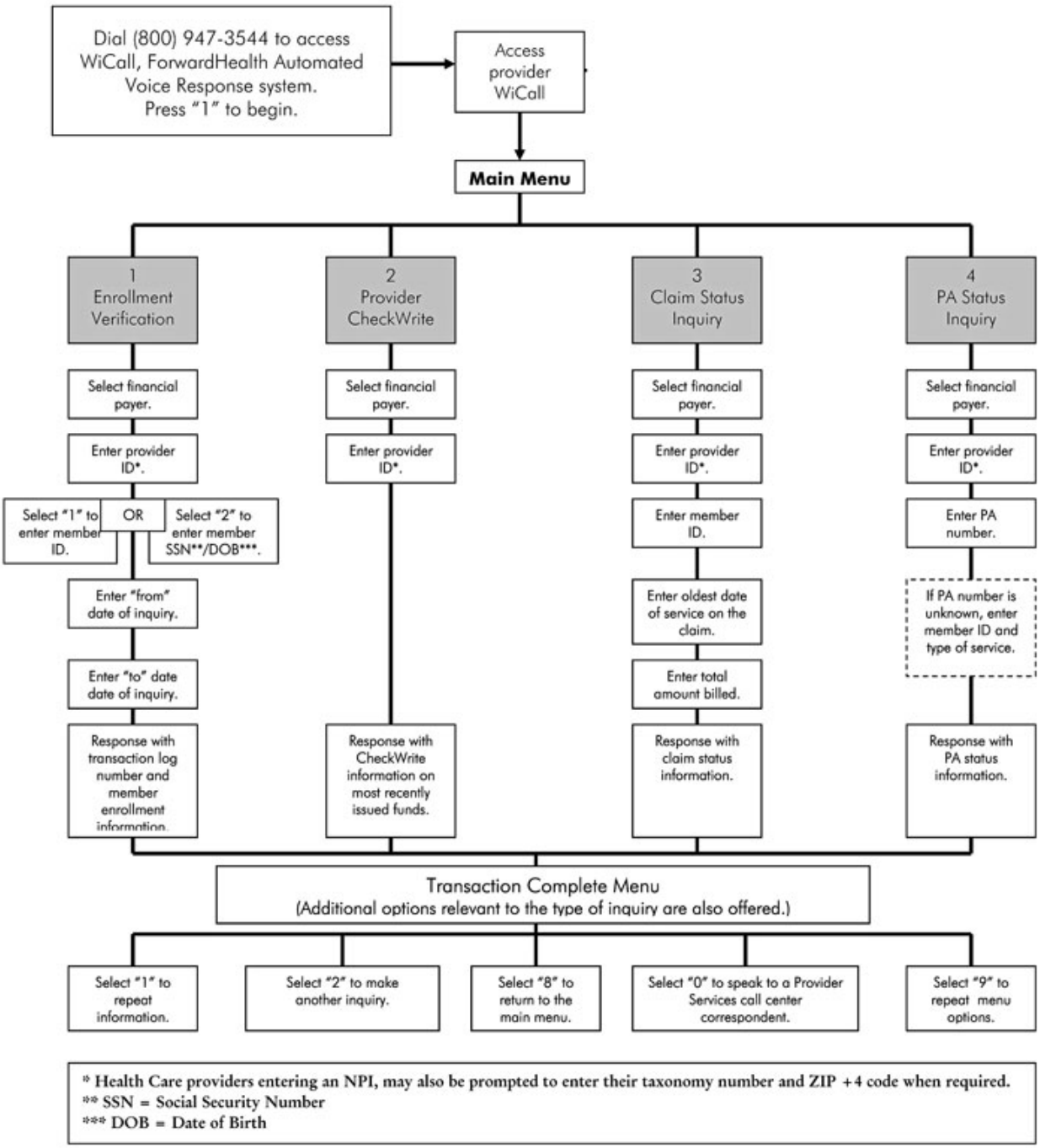
Note: PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

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