# Provider Enrollment and Ongoing Responsibilities

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# Provider Enrollment and Ongoing Responsibilities:Provider Enrollment

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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 #3430

# Licensed Hospital Facility

To be enrolled and reimbursed as a hospital by Wisconsin Medicaid, a facility must be licensed as a hospital by the DQA

(Division of Quality Assurance) under Wis. Stat. ch. 50. Therefore, a service may be reimbursed at Medicaid outpatient hospital rates **only** if it is provided in a building that is licensed by the DQA as a hospital. For licensure purposes, the hospital includes all inpatient rooms, surgical suites, and other facilities where services are performed for members. This policy is commonly referred to as the "4 walls policy." If the conditions of the ForwardHealth "4 walls policy" are met, Wisconsin Medicaid will typically reimburse both a professional charge and a facility charge. A professional charge is any charge billed on a professional claim for professional services. A facility charge is any charge billed by a hospital on an institutional claim.

Wisconsin Medicaid's reimbursement methodologies differ from the methodologies of the federal Medicare program. Medicare designates a provider-based status to certain remote or satellite facilities that are not located in a DQA-licensed hospital. Facilities with a provider-based status (according to 42 CFR § 413.65) receive Medicare's hospital reimbursement rates. ForwardHealth does not recognize Medicare's provider-based designation for these facilities; therefore, services provided at these facilities are not reimbursed at Medicaid outpatient hospital rates.

Because Wisconsin Medicaid does not recognize Medicare's provider-based designation, claims submitted to ForwardHealth for services provided at these facilities may **not** be submitted using a hospital's NPI (National Provider Identifier). Claims submitted to ForwardHealth for services provided at a facility outside a Medicaid-enrolled and DQA-licensed hospital must be submitted using the NPI of that outside facility. For example, when a claim is submitted by a freestanding facility that is outside, but affiliated with, a Medicaid-enrolled hospital or located on the same property as a Medicaid-enrolled hospital, the billing provider number's NPI for the freestanding facility must be indicated on the claim.

Topic #193

# Materials for New Providers

On an ongoing basis, providers should refer to the Online Handbook for the most current BadgerCare Plus, Medicaid, and ADAP (Wisconsin AIDS Drug Assistance Program) information. Future changes to policies and procedures are published in *ForwardHealth Updates*.

Topic #1372

# Multiple Services

## Durable Medical Equipment

For most DME (durable medical equipment), hospitals may either submit claims under their outpatient hospital NPI (National Provider Identifier) on the UB-04 Claim Form or they may enroll as a DME provider and submit claims under the unique DME NPI using the 1500 Health Insurance Claim Form ((02/12)).

However, outpatient hospitals are required to obtain separate Medicaid enrollment and a unique NPI as a DME provider before submitting claims for the following:

- Vagus nerve stimulators
- Bone-anchored hearing devices
- Cochlear implants

## Laboratory

As specified in Wis. Admin. Code § DHS 107.08(1)(b), covered outpatient hospital services must result from a member visit to the outpatient hospital. Medicaid-enrolled outpatient hospital providers may receive reimbursement for laboratory services only when the services result from a member outpatient visit.

Therefore, outpatient hospitals may only receive reimbursement resulting from specimens transferred from outside the hospital when the hospital laboratory becomes separately enrolled as an independent laboratory.

A laboratory located in a hospital must become separately enrolled as an independent laboratory if the laboratory accepts, or intends to accept, transferred specimens from any provider, clinic, or facility that is not included as part of the approved hospital facility. Hospital laboratories that only process specimens from the hospital system itself will be considered Medicaid-enrolled as a part of the hospital's enrollment.

## Hospital-Based Ambulance

All air, water, or land hospital-based ambulance services are required to meet the ambulance enrollment standards in Wis. Admin. Code § DHS 105.38. Hospitals providing these services are required to be individually enrolled as ambulance providers in order to receive reimbursement.

## Services Provided in Unapproved Facilities

Outpatient reimbursement is made only for services provided in a facility that is licensed by the DQA (Division of Quality Assurance) as a hospital. Claims for services provided outside a Medicaid-enrolled and DQA-licensed hospital must be submitted under a separate NPI using the claim form appropriate to the type of Medicaid service and provider category. For example, a freestanding facility that provides services on the same property as a Medicaid-enrolled hospital or is affiliated with a Medicaid-enrolled hospital must submit claims under its own NPI and taxonomy code, not under an NPI for outpatient hospital services.

As specified in Wis. Admin. Code § DHS 107.08(1)(b), covered outpatient hospital services must result from a member visit to the outpatient hospital, and a service may be reimbursed at outpatient hospital rates only if it is provided in a building that is licensed by the DQA as a hospital. For licensure purposes, the hospital includes all inpatient rooms, surgical suites, and other facilities where services are performed for inpatients.

### Substance Abuse and Mental Health Outpatient Clinic Services

If substance abuse and mental health outpatient clinic services are performed in an unapproved portion of a hospital, they are not outpatient hospital services. If this is the case, the facility must be separately enrolled in Wisconsin Medicaid for outpatient psychotherapy/substance abuse services. Mental health and substance abuse programs must obtain certification from the DQA before they can be enrolled as ForwardHealth programs.

## Substance Abuse and Mental Health Day Treatment

Substance abuse day treatment and mental health day treatment are not considered outpatient services; they are considered separate ForwardHealth services.

Topic #4457

# Provider Addresses

ForwardHealth has the capability to store the following types of addresses and contact information:

- **Practice location address and related information.** This address is where the provider's office is physically located and where records are normally kept. Additional information for the practice location includes the provider's office telephone number and the telephone number for members' use. With limited exceptions, the practice location and telephone number for members' use are published in a provider directory made available to the public.
- **Mailing address.** This address is where ForwardHealth will mail general information and correspondence. Providers

should indicate accurate address information to aid in proper mail delivery.
- **PA (prior authorization) address.** This address is where ForwardHealth will mail PA information.
- **Financial addresses.** Two separate financial addresses are stored for ForwardHealth. The checks address is where ForwardHealth will mail paper checks. The 1099 mailing address is where ForwardHealth will mail IRS Form 1099.

Providers may submit additional address information or modify their current information using the demographic maintenance tool.

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

Topic #14157

# Provider Enrollment Information Home Page

ForwardHealth has consolidated all information providers will need for the enrollment process in one location on the ForwardHealth Portal. For information related to enrollment criteria and to complete online provider enrollment applications, providers should refer to the Provider Enrollment Information home page.

The Provider Enrollment Information home page includes enrollment applications for each provider type and specialty eligible for enrollment with Wisconsin Medicaid. Prior to enrolling, providers may consult a provider enrollment criteria menu, which is a reference for each individual provider type detailing the information the provider may need to gather before beginning the enrollment process, including:

- Links to enrollment criteria for each provider type
- Provider terms of reimbursement
- Disclosure information
- Category of enrollment
- Additional documents needed (when applicable)

Providers will also have access to a list of links related to the enrollment process, including:

- General enrollment information
- Regulations and forms
- Provider type-specific enrollment information
- In-state and out-of-state emergency enrollment information
- Contact information

Information regarding enrollment policy and billing instructions may still be found in the Online Handbook.

Topic #1931

# Provider Type and Specialty Changes

## Provider Type

Providers who want to add a provider type or change their current provider type are required to complete a new enrollment application for each provider type they want to add or change to because they need to meet the enrollment criteria for each provider type.

## Provider Specialty

Providers who have the option to add or change a provider specialty can do so using the demographic maintenance tool. After adding or changing a specialty, providers may be required to submit documentation to ForwardHealth, either by uploading through the demographic maintenance tool or by mail, supporting the addition or change.

Providers should contact Provider Services with any questions about adding or changing a specialty.

Topic #22257

# Providers Have 35 Days to Report a Change in Ownership

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

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

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

## Written Notification and a New Enrollment Application Are Required

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

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

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

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

### Special Requirements for Specific Provider Types

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

- Ambulatory surgery centers
- CHCs (Community Health Centers)
- ESRD (End Stage Renal Disease) services providers
- Home health agencies
- Hospice providers
- Hospitals (inpatient and outpatient)
- Nursing homes
- Outpatient rehabilitation facilities

- Rehabilitation agencies
- RHCs (Rural Health Clinics)
- Tribal FQHCs (Federally Qualified Health Centers)

# Events That ForwardHealth Considers a Change in Ownership

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

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

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

## Examples of a Change in Ownership

Examples of a change in ownership include the following:

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

# End Date of Previous Owner's Enrollment

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

# Repayment Following a Change in Ownership

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

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

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

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

Office of the Inspector General

PO Box 309
Madison WI 53701-0309

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

# Automatic Recoupment Following a Change in Ownership

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

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

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

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

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

# Submitting Claims After a Change in Ownership

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

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

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

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

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

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

## For Further Questions

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

Topic #14317

# Terminology to Know for Provider Enrollment

Due to the ACA (Affordable Care Act), ForwardHealth has adopted new terminology. The following table includes new terminology that will be useful to providers during the provider enrollment and revalidation processes. Providers may refer to the Medicaid rule 42 C.F.R. s. 455.101 for more information.

| New Terminology | Definition |
|---|---|
| Agent | Any person who has been delegated the authority to obligate or act on behalf of a provider. |
| Disclosing entity | A Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent. |
| Federal health care programs | Federal health care programs include Medicare, Medicaid, Title XX, and Title XXI. |
| Other disclosing agent | Any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVII, or XX of the Act. This includes:<br>- 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)<br>- Any Medicare intermediary or carrier<br>- 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:<br>- Has an ownership interest totaling five percent or more in a disclosing entity<br>- Has an indirect ownership interest equal to five percent or more in a disclosing entity<br>- Has a combination of direct and indirect ownership interest equal to five percent or more in a disclosing entity<br>- 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<br>- Is an officer or director of a disclosing entity that is organized as a corporation<br>- 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,<br>- 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.

# Ongoing Responsibilities

Topic #220

## Accommodating Members With Disabilities

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

Topic #219

## Civil Rights Compliance (Nondiscrimination)

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

- Title VI and VII of the Civil Rights Act of 1964
- The Age Discrimination Act of 1975
- Section 504 of the Rehabilitation Act of 1973
- The ADA (Americans With Disabilities Act) of 1990

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

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

- Denial of aid, care, services, or other benefits
- Segregation or separate treatment
- Restriction in any way of any advantage or privilege received by others (There are some program restrictions based on eligibility classifications.)
- Treatment different from that given to others in the determination of eligibility
- Refusing to provide an oral language interpreter to persons who are considered LEP (limited English proficient) at no cost to the LEP individual in order to provide meaningful access
- Not providing translation of vital documents to the LEP groups who represent 5 percent or 1,000, whichever is smaller, in the provider's area of service delivery

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

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

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

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

For more information on the acts protecting members from discrimination, refer to the civil rights compliance information in the Enrollment and Benefits booklet. The booklet is given to new ForwardHealth members by local county or tribal agencies. Potential ForwardHealth members can request the booklet by calling Member Services.

# Title VI of the Civil Rights Act of 1964

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

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

# Title VII of the Civil Rights Act of 1964

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

# Federal Rehabilitation Act of 1973, Section 504

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

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

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

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

## Americans With Disabilities Act of 1990

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

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

## Age Discrimination Act of 1975

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

Topic #198

# Contracted Staff

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

When contracting services, providers are required to ensure contracted agencies are qualified to provide services, meet all ForwardHealth and program requirements, and maintain records in accordance with the requirements for the provision of services.

Medicaid requirements do not relieve contracted agencies of their own regulatory requirements. Contracted agencies are required to continue to meet their own regulatory requirements, in addition to ForwardHealth requirements.

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

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

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

Topic #216

# Examples of Ongoing Responsibilities

Responsibilities for which providers are held accountable are described throughout the Online Handbook. Medicaid-enrolled providers have responsibilities that include, but are not limited to, the following:

- Providing the same level and quality of care to ForwardHealth members as private-pay patients
- Complying with all state and federal laws related to ForwardHealth
- Obtaining PA (prior authorization) for services, when required
- Notifying members in advance if a service is not covered by ForwardHealth and the provider intends to collect payment from the member for the service
- Maintaining accurate medical and billing records
- Retaining preparation, maintenance, medical, and financial records, along with other documentation, for a period of not less than five years from the date of payment, except rural health clinic providers who are required to retain records for a minimum of six years from the date of payment
- Billing only for services that were actually provided
- Allowing a member access to their records
- Monitoring contracted staff
- Accepting Medicaid reimbursement as payment in full for covered services
- Keeping provider information (i.e., address, business name) current
- Notifying ForwardHealth of changes in ownership
- Responding to Medicaid revalidation notifications
- Safeguarding member confidentiality
- Verifying member enrollment
- Keeping up-to-date with changes in program requirements as announced in ForwardHealth publications

Topic #217

# Keeping Information Current

## Changes That Require ForwardHealth Notification

Providers are required to notify ForwardHealth of any changes to their demographic information, including the following, as they occur:

- Address(es) — practice location and related information, mailing, PA (prior authorization), and/or financial

  *Note:* Health care providers who are federally required to have an NPI (National Provider Identifier) are cautioned that changes to their practice location address on file with ForwardHealth may alter their ZIP+4 code information that is required on transactions.

- Business name
- Contact name
- Federal Tax ID number (IRS (Internal Revenue Service) number)
- Group affiliation
- Licensure
- NPI
- Ownership
- Professional certification
- Provider specialty
- Supervisor of nonbilling providers
- Taxonomy code
- Telephone number, including area code

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

- Incorrect reimbursement

- Misdirected payment
- Claim denial
- Suspension of payments or cancellation of provider file if provider mail is returned to ForwardHealth for lack of a current address

Entering new information on a claim form or PA request is **not** adequate notification of change.

### Notifying ForwardHealth of Changes

Providers can notify ForwardHealth of changes using the demographic maintenance tool.

### Providers Enrolled in Multiple Programs

If demographic information changes, providers enrolled in multiple programs (e.g., Wisconsin Medicaid and WCDP (Wisconsin Chronic Disease Program)) will need to change the demographic information for each program. By toggling between accounts using the Switch Organization function of the Portal, providers who have a Portal account for each program can change their information for each program using the demographic maintenance tool. The Account User Guide provides specific information about switching organizations.

### Providers Licensed or Certified by the Division of Quality Assurance

Providers licensed or certified by the DQA (Division of Quality Assurance) are required to notify the DQA of changes to physical address, changes of ownership, and facility closures by emailing Lisa.Imhof@dhs.wisconsin.gov.

Topic #577

## Legal Framework

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

- Federal Law and Regulation:
  - Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI
  - Regulation — Title 42 C.F.R. Parts 430-498 and Parts 1000-1008 (Public Health)
- Wisconsin Law and Regulation:
  - Law — Wis. Stat. §§ 49.43-49.499, 49.665, and 49.473
  - Regulation — Wis. Admin. Code chs. DHS 101, 102, 103, 104, 105, 106, 107, and 108

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

The information included in the ForwardHealth Portal applies to BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid. BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid are administered by the Wisconsin DHS (Department of Health Services). Within DHS, DMS (Division of Medicaid Services) is directly responsible for managing these programs.

Topic #17097

## Licensure Information

Licensed providers are required to keep all licensure information, including license number, grant and expiration dates, and physical location as applicable (e.g., hospital providers), current with ForwardHealth.

If providers do not keep their licensure information, including their license number, current with ForwardHealth, any of the following may occur:

- Providers' enrollment may be deactivated. As a result, providers would not be able to submit claims or PA (prior authorization) requests or be able to function as prescribing/referring/ordering providers, if applicable, until they update their licensure information.
- Providers may experience a lapse in enrollment. If a lapse occurs, providers may need to re-enroll, which may result in another application fee being assessed.

Providers may change the grant and expiration dates for their current license(s) and enter information for a new license(s), such as the license number, licensing state, and grant and expiration dates, using the demographic maintenance tool. After entering information for their new license(s), some providers (e.g., out-of-state providers) will also be required to upload a copy of their license using the demographic maintenance tool. Provided licensure information must correspond with the information on file with the applicable licensing authority.

In some cases, ForwardHealth will need to verify licensure information with the applicable licensing authority, which may take up to 10 business days after submission. Providers updating their license information should plan accordingly so that they do not experience any of the indicated interruptions in enrollment. If provided licensure information (e.g., grant and expiration dates) does not correspond with the licensing authority's information, the licensing authority's information will be retained and will display in the demographic maintenance tool once verified by ForwardHealth.

Topic #15157

# Recovery Audit Contractor Audits

The ACA (Affordable Care Act) requires states to establish an RAC (Recovery Audit Contractor) program to enable the auditing of Medicaid claim payments to providers. In Wisconsin, the RAC will audit claim payments from Wisconsin Medicaid and BadgerCare Plus. The Wisconsin DHS (Department of Health Services) has awarded the contract to HMS (Health Management Systems, Inc.) as the RAC for the state of Wisconsin.

*Note:* The RAC will not audit claims submitted for Family Planning Only Services, SeniorCare, WCDP (Wisconsin Chronic Disease Program), the WWWP (Wisconsin Well Woman Program), and ADAP (Wisconsin AIDS Drug Assistance Program).

The overall goal of the RAC program is to identify and decrease improper payments. The audits will ensure that payments are for services covered under the programs in which the member was enrolled and that the services were actually provided and properly billed and documented. The audits are being conducted under Generally Accepted Government Auditing Standards.

Providers will be selected for audits based on data analysis by the RAC and referrals by state agencies. The RAC will ensure that its audits neither duplicate state audits of the same providers nor interfere with potential law enforcement investigations.

Providers who receive a notification regarding an audit should follow the instructions as outlined in the notification within the requested time frames.

## Affected Providers

Any provider may be audited, including, but not limited to, fee-for-service providers, institutional and non-institutional providers, as well as managed care entities.

## Additional Information

Any questions regarding the RAC program should be directed to HMS at 855-699-6289. Refer to the RAC website for additional information regarding HMS RAC activities.

Topic #13277

# Reporting Suspected Waste, Fraud, and Abuse

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

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

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

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

## Reporting Suspected Fraud and Abuse

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

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

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

The following information is helpful when reporting fraud and abuse:

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

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

# Documentation

Topic #6277

## 1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than $600.00, per IRS (Internal Revenue Service) regulations. One 1099 Miscellaneous form per financial payer and per tax identification number is generated, regardless of how many provider IDs or NPIs (National Provider Identifier) share the same tax identification number. For example, a provider who conducts business with both Medicaid and WCDP (Wisconsin Chronic Disease Program) will receive separate 1099 Miscellaneous forms for each program.

The 1099 Miscellaneous forms are sent to the address designated as the "1099 mailing address."

Topic #1640

## Availability of Records to Authorized Personnel

The Wisconsin DHS (Department of Health Services) has the right to inspect, review, audit, and reproduce provider records pursuant to Wis. Admin. Code § DHS 106.02(9)(e). The DHS periodically requests provider records for compliance audits to match information against ForwardHealth's information on paid claims, PA (prior authorization) requests, and enrollment. These records include, but are not limited to, medical/clinical and financial documents. Providers are obligated to ensure that the records are released to an authorized DHS staff member(s).

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

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

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

The reproduction of records requested by the PRO (Peer Review Organization) under contract with the DHS is reimbursed at a rate established by the PRO.

Topic #200

## Confidentiality and Proper Disposal of Records

ForwardHealth supports member rights regarding the confidentiality of health care and other related records, including an applicant or member's billing information or medical claim records. An applicant or member has a right to have this information safeguarded, and the provider is obligated to protect that right. Use or disclosure of any information concerning an applicant or member (including an applicant or member's billing information or medical claim records) for any purpose not connected with program administration is prohibited unless authorized by the applicant or member (program administration includes contacts with third-party payers that are necessary for pursuing third-party payment and the release of information as ordered by the court).

Federal HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy and Security regulations establish requirements regarding the confidentiality and proper disposal of health care and related records containing PHI (protected health information). These requirements apply to all providers (who are considered "covered entities") and their business associates who create, retain, and dispose of such records.

For providers and their business partners who are not subject to HIPAA, Wisconsin confidentiality laws have similar requirements pertaining to proper disposal of health care and related records.

# HIPAA Privacy and Security Regulations

## Definition of Protected Health Information

As defined in the HIPAA privacy and security regulations, PHI is protected health information (including demographic information) that:

- Is created, received, maintained, or transmitted in any form or media.
- Relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the payment for the provision of health care to an individual.
- Identifies the individual or provides a reasonable basis to believe that it can be used to identify the individual.

A member's name combined with their member identification number or Social Security number is an example of PHI.

## Requirements Regarding "Unsecured" Protected Health Information

Title XIII of the American Recovery and Reinvestment Act of 2009 (also known as the HITECH (Health Information Technology for Economic and Clinical Health) Act) included a provision that significantly expanded the scope, penalties, and compliance challenges of HIPAA. This provision imposes new requirements on covered entities and their business associates to notify patients, the federal government, and the media of breaches of "unsecured" PHI (refer to 45 C.F.R. Parts 160 and 164 and § 13402 of the HITECH Act).

Unsecured PHI is PHI that has not been rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of physical destruction approved by the U.S. HHS (Department of Health and Human Services). According to HHS, destruction is the only acceptable method for rendering PHI unusable, unreadable, or indecipherable.

As defined by federal law, unsecured PHI includes information in **any** medium, not just electronic data.

## Actions Required for Proper Disposal of Records

Under the HIPAA privacy and security regulations, health care and related records containing PHI must be disposed of in such a manner that they cannot be reconstructed. This includes ensuring that the PHI is secured (i.e., rendered unusable, unreadable, or indecipherable) prior to disposal of the records.

To secure PHI, providers and their business associates are required to use one of the following destruction methods approved by the HHS:

- Paper, film, labels, or other hard copy media should be shredded or destroyed such that the PHI cannot be read or otherwise reconstructed.
- Electronic media should be cleared, purged, or destroyed such that the PHI cannot be retrieved according to National Institute of Standards and Technology Special Publication 800-88, Guidelines for Media Sanitization, which can be found on the NIST (National Institute of Standards and Technology) website.

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

# Wisconsin Confidentiality Laws

Wis. Stat. § 134.97 requires providers and their business partners who are not subject to HIPAA regulations to comply with Wisconsin confidentiality laws pertaining to the disposal of health care and related records containing PHI.

Wis. Stat. § 146.836 specifies that the requirements apply to "all patient health care records, including those on which written, drawn, printed, spoken, visual, electromagnetic or digital information is recorded or preserved, regardless of physical form or characteristics." Paper **and** electronic records are subject to Wisconsin confidentiality laws.

## "Personally Identifiable Data" Protected

According to Wis. Stat. § 134.97(1)(e), the types of records protected are those containing "personally identifiable data."

As defined by the law, personally identifiable data is information about an individual's medical condition that is not considered to be public knowledge. This may include account numbers, customer numbers, and account balances.

## Actions Required for Proper Disposal of Records

Health care and related records containing personally identifiable data must be disposed of in such a manner that no unauthorized person can access the personal information. For the period of time between a record's disposal and its destruction, providers and their business partners are required to take actions that they reasonably believe will ensure that no unauthorized person will have access to the personally identifiable data contained in the record.

## Businesses Affected

Wis. Stat.§§ 134.97 and 134.98, governing the proper disposal of health care and related records, apply to medical businesses as well as financial institutions and tax preparation businesses. For the purposes of these requirements, a medical business is any for-profit or nonprofit organization or enterprise that possesses information — other than personnel records — relating to a person's physical or mental health, medical history, or medical treatment. Medical businesses include sole proprietorships, partnerships, firms, business trusts, joint ventures, syndicates, corporations, limited liability companies, or associates.

# Continuing Responsibilities for All Providers After Ending Participation

Ending participation in a ForwardHealth program does not end a provider's responsibility to protect the confidentiality of health care and related records containing PHI.

Providers who no longer participate in a ForwardHealth program are responsible for ensuring that they and their business associates/partners continue to comply with all federal and state laws regarding protecting the confidentiality of members' PHI. Once record retention requirements expire, records must be disposed of in such a manner that they cannot be reconstructed — according to federal and state regulations — in order to avoid penalties.

All ForwardHealth providers and their business associates/partners who cease practice or go out of business should ensure that they have policies and procedures in place to protect all health care and related records from any unauthorized disclosure and use.

# Penalties for Violations

Any covered entity provider or provider's business associate who violates federal HIPAA regulations regarding the confidentiality and proper disposal of health care and related records may be subject to criminal and/or civil penalties, including any or all of the following:

- Fines up to $1.5 million per calendar year

- Jail time
- Federal HHS Office of Civil Rights enforcement actions

For entities not subject to HIPAA, Wis. Stat. § 34.97(4) imposes penalties for violations of confidentiality laws. Any provider or provider's business partner who violates Wisconsin confidentiality laws may be subject to fines up to $1,000 per incident or occurrence.

For more specific information on the penalties for violations related to members' health care records, providers should refer to § 13410(d) of the HITECH Act, which amends 42 USC § 1320d-5, and Wis. Stat. §§ 134.97(3), (4) and 146.84.

Topic #201

# Financial Records

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

Topic #202

# Medical Records

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

Topic #199

# Member Access to Records

Providers are required to allow members access to their health care records, including those related to ForwardHealth services, maintained by a provider in accordance with Wisconsin Statutes, excluding billing statements.

## Fees for Health Care Records

Per Wis. Stat. § 146.83, providers may charge a fee for providing one set of copies of health care records to members who are enrolled in Wisconsin Medicaid or BadgerCare Plus programs on the date of the records request. This applies regardless of the member's enrollment status on the DOS (dates of service) contained within the health care records.

Per Wis. Stat. § 146.81(4), health care records are all records related to the health of a patient prepared by, or under the supervision of, a health care provider.

Providers are limited to charging members enrolled in state-funded health care programs 25 percent of the applicable fees for providing one set of copies of the member's health care records.

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

The Wisconsin DHS (Department of Health Services) adjusts the amounts a provider may charge for providing copies of a member's health care records yearly per Wis. Stat. § 146.83(3f)(c).

Topic #16157

# Policy Requirements for Use of Electronic Signatures on Electronic Health Records

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

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

## Electronic Signature Definition

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

Some examples include:

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

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

## Benefits of Using Electronic Signatures

The use of electronic signatures will allow providers to:

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

## Electronic Signature Requirements

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

### General Requirements

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

- The electronic signature must be under the sole control of the rendering provider. Only the rendering provider or designee has the authority to use the rendering provider's electronic signature. Providers are required to maintain documentation that shows the electronic signature that belongs to each rendering provider if a numbering or initial system is used (e.g., what number is assigned to a specific rendering provider). This documentation must be kept confidential.
- The provider is required to have current policies and procedures regarding the use of electronic signatures. The Wisconsin DHS (Department of Health Services) recommends the provider conduct an annual review of policies and procedures with

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

### Electronic Health Record Signature Requirements

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

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

Topic #203

# Preparation and Maintenance of Records

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

Topic #204

# Record Retention

Providers are required to retain documentation, including medical and financial records, for a period of not less than five years from the date of payment, except RHCs (rural health clinics), which are required to retain records for a minimum of six years from the date of payment.

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

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

## Maintaining Confidentiality of Records

Ending participation in a ForwardHealth program does not end a provider's responsibility to protect the confidentiality of health care and related records containing PHI (protected health information).

Providers who no longer participate in a ForwardHealth program are responsible for ensuring that they and their business associates/partners continue to comply with all federal and state laws regarding protecting the confidentiality of members' PHI. Once record retention requirements expire, records must be disposed of in such a manner that they cannot be reconstructed — according to federal and state regulations — in order to avoid penalties. For more information on the proper disposal of records, refer to Confidentiality and Proper Disposal of Records.

All ForwardHealth providers and their business associates/partners who cease practice or go out of business should ensure that they have policies and procedures in place to protect all health care and related records from any unauthorized disclosure and use.

## Reviews and Audits

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

Topic #205

# Records Requests

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

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

## Request From a Member or Authorized Person

If the request for a member's billing information or medical claim records is from a member or authorized person acting on behalf of a member, the provider is required to do the following:

1. Send a copy of the requested billing information or medical claim records to the requestor.

2. Send a letter containing the following information to ForwardHealth:
    - Member's name
    - Member's ForwardHealth identification number or SSN (Social Security number), if available
    - Member's DOB (date of birth)
    - DOS (date of service)
    - Entity requesting the records, including name, address, and telephone number

    The letter must be sent to the following address:

    Wisconsin Casualty Recovery — HMS
    Ste 100
    5615 Highpoint Dr
    Irving TX 75038-9984

# Request From an Attorney, Insurance Company, or Power of Attorney

If the request for a member's billing information or medical claim records is from an attorney, insurance company, or power of attorney, the provider is required to do the following:

1. Obtain a release signed by the member or authorized representative.
2. Furnish the requested material to the requester, marked "BILLED TO FORWARDHEALTH" or "TO BE BILLED TO FORWARDHEALTH," with a copy of the release signed by the member or authorized representative. Approval from ForwardHealth is not necessary.
3. Send a copy of the material furnished to the requestor, along with a copy of their original request and medical authorization release to:

    Wisconsin Casualty Recovery — HMS
    Ste 100
    5615 Highpoint Dr
    Irving TX 75038-9984

# Request for Information About a Member Enrolled in a State-Contracted Managed Care Organization

If the request for a member's billing information or medical claim records is for a member enrolled in a state-contracted MCO (managed care organization), the provider is required to do the following:

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

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

# Request for a Statement From a Dual Eligible

If the request is for an itemized statement from a dual eligible, pursuant to HR 2015 (Balanced Budget Act of 1997) § 4311, a dual eligible has the right to request and receive an itemized statement from their Medicare-enrolled health care provider. The Act requires the provider to furnish the requested information to the member. The Act does **not** require the provider to notify ForwardHealth.

Topic #1646

# Release of Billing Information to Government Agencies

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

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

# Provider Rights

Topic #208

## A Comprehensive Overview of Provider Rights

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

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

Topic #207

## Ending Participation

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

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

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

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

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

Wisconsin Medicaid
Provider Enrollment
313 Blettner Blvd
Madison WI 53784

If the provider fails to specify an effective date in the notice of termination, ForwardHealth may terminate the provider on the date the notice is received.

Topic #209

## Hearing Requests

A provider who wishes to contest a Wisconsin DHS (Department of Health Services) action or inaction for which due process is required under Wis. Stat. ch. 227, may request a hearing by writing to the DHA (Division of Hearings and Appeals).

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

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

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

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

Topic #210

# Limiting the Number of Members

If providers choose to limit the number of members they see, they cannot accept a member as a private-pay patient. Providers should instead refer the member to another ForwardHealth provider.

Persons applying for or receiving benefits are protected against discrimination based on race, color, national origin, sex, religion, age, disability, or association with a person with a disability.

Topic #206

# Requesting Discretionary Waivers and Variances

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

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

## Requirements

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

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

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

## Application

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

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

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

Division of Medicaid Services
Waivers and Variances
PO Box 309
Madison WI 53701-0309

# Sanctions

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Topic #211

## Intermediate Sanctions

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

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

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

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

Topic #212

## Involuntary Termination

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

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

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

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

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

Topic #213

## Sanctions for Collecting Payment From Members

Under state and federal laws, if a provider inappropriately collects payment from an enrolled member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid enrollment. In addition, the provider may also be fined not more than $25,000, or imprisoned not more than five years, or both, pursuant to 42 USC § 1320a-7b(d) or Wis. Stat. § 49.49(3m).

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

Topic #214

# Withholding Payments

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

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

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

# Prescription

Topic #525

# General Requirements

It is vital that prescribers provide adequate supporting clinical documentation for a pharmacy or other dispensing providers to fill a prescription. Except as otherwise provided in federal or state law, a prescription must be in writing or given orally and later reduced to writing by the provider filling the prescription. The prescription must include the following information:

- The name, strength, and quantity of the drug or item prescribed
- The service required, if applicable
- The date of issue of the prescription
- The prescriber's name and address
- The member's name and address
- The prescriber's signature (if the prescriber writes the prescription) and date signed
- The directions for use of the prescribed drug, item, or service

## Drug Enforcement Agency Number Audits

All prescriptions for controlled substances must indicate the DEA (Drug Enforcement Agency) number of the prescriber on all prescriptions. DEA numbers are not required on claims or PAs (prior authorizations).

## Members in Hospitals and Nursing Homes

For hospital and nursing home members, prescriptions must be entered into the medical and nursing charts and must include the previously listed information. Prescription orders are valid for no more than one year from the date of the prescription except for controlled substances and prescriber-limited refills that are valid for shorter periods of time.

Topic #523

# Prescriber Information for Drug Prescriptions

Most legend and certain OTC (over-the-counter) drugs are covered. (A legend drug is one whose outside package has the legend or phrase "Caution, federal law prohibits dispensing without a prescription" printed on it.)

Coverage for some drugs may be restricted by one of the following policies:

- PDL (Preferred Drug List)
- PA (prior authorization)
- BBG (brand before generic) drugs that require PA
- BMN (brand medically necessary) drugs that require PA
- Diagnosis-restricted drugs
- Age-restricted drugs
- Quantity limits

Prescribers are encouraged to write prescriptions for drugs that do not have restrictions; however, processes are available to obtain reimbursement for medically necessary drugs that do have restrictions.

For the most current prescription drug information, refer to the pharmacy data tables. Providers may also call Provider Services for more information.

# Preferred Drug List

Most preferred drugs on the PDL do **not** require PA, although these drugs may have other restrictions (for example, age, diagnosis); non-preferred drugs **do** require PA. Prescribers are encouraged to write prescriptions for preferred drugs; however, a PA process is available for non-preferred drugs if the drugs are medically necessary.

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

### Prescriber Responsibilities for Non-Preferred Drugs

If a member is enrolled in BadgerCare Plus, Wisconsin Medicaid, or SeniorCare, prescribers are encouraged to write prescriptions for preferred drugs. Prescribers are encouraged to prescribe **more than one** preferred drug before a non-preferred drug is prescribed from the same drug class.

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

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

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

# Diagnosis-Restricted Drugs

Prescribers are required to indicate a diagnosis on prescriptions for all drugs that are identified by ForwardHealth as diagnosis-restricted.

# Prescribing Drugs Manufactured by Companies Who Have Not Signed the Rebate Agreement

By federal law, pharmaceutical manufacturers who participate in state Medicaid programs must sign a rebate agreement with CMS (Centers for Medicare & Medicaid Services). BadgerCare Plus, Wisconsin Medicaid, and SeniorCare will cover legend and specific categories of OTC products of manufacturers who have signed a rebate agreement.

Note: SeniorCare does not cover OTC drugs, except insulin.

ForwardHealth has identified drug manufacturers who have signed the rebate agreement. By signing the rebate agreement, the manufacturer agrees to pay ForwardHealth a rebate equal to a percentage of its "sales" to ForwardHealth.

Drugs of companies choosing not to sign the rebate agreement, with few exceptions, are not covered. A Medicaid-enrolled pharmacy can confirm for prescribers whether or not a particular drug manufacturer has signed the agreement.

## Members Enrolled in BadgerCare Plus, Wisconsin Medicaid, or SeniorCare (Levels 1 and 2A)

BadgerCare Plus, Medicaid, and SeniorCare levels 1 and 2A may cover certain FDA (Food and Drug Administration)-approved legend drugs through the PA process even though the drug manufacturers did not sign rebate agreements.

Prescribers are required to complete the appropriate section(s) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/2016)) as it pertains to the drug being requested.

Included with the PA request, the prescriber is required to submit documentation of medical necessity and cost-effectiveness that the non-rebated drug is the only available and medically appropriate product for treating the member. The documentation must include the following:

- A copy of the medical record or documentation of the medical history detailing the member's medical condition and previous treatment results
- Documentation by the prescriber that shows why other drug products have been ruled out as ineffective or unsafe for the member's medical condition
- Documentation by the prescriber that shows why the non-rebated drug is the most appropriate and cost-effective drug to treat the member's medical condition

If a PA request for a drug without a signed manufacturer rebate is approved, claims for drugs without a signed rebate agreement must be submitted on paper. Providers should complete and submit the Noncompound Drug Claim (F-13072 (04/2017)) form indicating the actual NDC (National Drug Code) of the drug with the Pharmacy Special Handling Request (F-13074 (04/2014)) form.

If a PA request for a drug without a signed manufacturer rebate is denied, the service is considered noncovered.

## Members Enrolled in SeniorCare (Levels 2B and 3)

PA is not available for drugs from manufacturers without a separate, signed SeniorCare rebate agreement for members in levels 2B and 3. PA requests submitted for drugs without a separate, signed SeniorCare rebate agreement for members in levels 2B and 3 will be returned to the providers unprocessed and the service will be noncovered. Members do not have appeal rights regarding returned PA requests for noncovered drugs.

## Prospective Drug Utilization Review System

The federal OBRA (Omnibus Budget Reconciliation Act) of 1990 (42 C.F.R. Parts 456.703 and 456.705) called for a DUR (Drug Utilization Review) program for all Medicaid-covered drugs to improve the quality and cost-effectiveness of member care. ForwardHealth's prospective DUR system assists pharmacy providers in screening certain drug categories for clinically important potential drug therapy problems before the prescription is dispensed to the member. The prospective DUR system checks the member's entire pharmacy paid claims history regardless of where the drug was dispensed or by whom it was prescribed.

Diagnoses from medical claims are used to build a disease or pregnancy profile for each member. The prospective DUR system uses this profile to determine whether or not a prescribed drug may be inappropriate or harmful to the member. It is very important that prescribers provide up-to-date medical diagnosis information about members on medical claims to ensure complete and accurate member profiles, particularly in cases of disease or pregnancy.

Note: The prospective DUR system does not dictate which drugs may be dispensed; prescribers and pharmacists must exercise professional judgment.

### Prospective Drug Utilization Review's Impact on Prescribers

If a pharmacy receives a prospective DUR alert, a DUR segment is required before the drug can be dispensed to the member. This may require the pharmacist to contact the prescriber for additional information to determine if the prescription should be filled as written, modified, or cancelled.

## Drugs With Three-Month Supply Requirement

ForwardHealth has identified a list of three-month supply drugs:

- Certain drugs are required to be dispensed in a three-month supply.
- Additional drugs are allowed to be dispensed in a three-month supply.

### Member Benefits

When it is appropriate for the member's medical condition, a three-month supply of a drug benefits the member in the following ways:

- Aiding compliance in taking prescribed generic, maintenance medications
- Reducing the cost of member copays
- Requiring fewer trips to the pharmacy
- Allowing the member to obtain a larger quantity of generic, maintenance drugs for chronic conditions (for example, hypertension)

Prescribers are encouraged to write prescriptions for a three-month supply when appropriate for the member.

### Prescription Quantity

A prescriber is required to indicate the appropriate quantity on the prescription to allow the dispensing provider to dispense the maintenance drug in a three-month supply. For example, if the prescription is written for "Hydrochlorothiazide 25 mg, take one tablet daily," the prescriber is required to indicate a quantity of 90 or 100 tablets on the prescription so the pharmacy provider can dispense a three-month supply. In certain instances, brand name drugs (for example, oral contraceptives) may be dispensed in a three-month supply.

Pharmacy providers are not required to contact prescribers to request a new prescription for a three-month supply if a prescription has been written as a one-month supply with multiple or as needed (that is, PRN (pro re nata)) refills.

ForwardHealth will not audit or recoup three-month supply claims if a pharmacy provider changes a prescription written as a one-month supply with refills as long as the total quantity dispensed per prescription does not exceed the total quantity authorized by the prescriber.

## Prescription Mail Delivery

Current Wisconsin law permits Medicaid-enrolled retail pharmacies to deliver prescriptions to members via the mail. Medicaid-enrolled retail pharmacies may dispense and mail any prescription or OTC medication to a Medicaid fee-for-service member at no additional cost to the member or Wisconsin Medicaid.

Providers are encouraged to use the mail delivery option if requested by the member, particularly for prescriptions filled for a three-month supply.

## Noncovered Drugs

The following drugs are not covered:

- Drugs that are identified by the FDA as LTE (less-than-effective) or identical, related, or similar to LTE drugs
- Drugs identified on the Wisconsin Negative Formulary
- Drugs manufactured by companies that have not signed the rebate agreement
- Drugs to treat the condition of ED (erectile dysfunction). Examples of noncovered drugs for ED are tadalafil (Cialis) and sildenafil (Viagra).

## SeniorCare

SeniorCare is a prescription drug assistance program for Wisconsin residents who are 65 years of age or older and meet eligibility criteria. SeniorCare is modeled after Wisconsin Medicaid in terms of drug coverage and reimbursement, although there are a few differences. Unlike Wisconsin Medicaid, SeniorCare does not cover OTC drugs other than insulin. SeniorCare also covers vaccines that are approved by the CDC (Centers for Disease Control and Prevention) ACIP (Advisory Committee on Immunization Practices) for people age 65 and older and are administered through a pharmacy.

Topic #4346

# Tamper-Resistant Prescription Pad Requirement

Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 imposed a requirement on prescriptions paid for by Medicaid, SeniorCare, or BadgerCare fee-for-service. The law requires that all written or computer-generated prescriptions that are given to a patient to take to a pharmacy must be written or printed on tamper-resistant prescription pads or tamper-resistant computer paper. This requirement applies to prescriptions for both controlled and noncontrolled substances.

All other Medicaid policies and procedures regarding prescriptions continue to apply.

## Required Features for Tamper-Resistant Prescription Pads or Computer Paper

To be considered tamper-resistant, federal law requires that prescription pads/paper contain all three of the following characteristics:

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms

## Exclusions to Tamper-Resistant Prescription Pad Requirement

The following are exclusions to the tamper-resistant prescription pad requirement:

- Prescriptions faxed directly from the prescriber to the pharmacy
- Prescriptions electronically transmitted directly from the prescriber to the pharmacy
- Prescriptions telephoned directly from the prescriber to the pharmacy
- Prescriptions provided to members in nursing facilities, ICF/IIDs (Intermediate Care Facilities for Individuals with Intellectual Disabilities), and other specified institutional and clinical settings to the extent that drugs are part of their overall rate (However, written prescriptions filled by a pharmacy outside the walls of the facility are subject to the tamper-resistant

requirement.)

## 72-Hour Grace Period

Prescriptions presented by patients on non-tamper-resistant pads or paper may be dispensed and considered compliant if the pharmacy receives a compliant prescription order within 72 hours.

## Coordination of Benefits

The federal law imposing these new requirements applies even when ForwardHealth is the secondary payer.

## Retroactive ForwardHealth Eligibility

If a patient becomes retroactively eligible for ForwardHealth, the federal law presumes that prescriptions retroactively dispensed were compliant. However, prospective refills will require a tamper-resistant prescription.

## Penalty for Noncompliance

Payment made to the pharmacy for a claim corresponding to a noncompliant order may be recouped, in full, by Wisconsin Medicaid.

# Provider Numbers

Topic #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 #12337

# Subpart National Provider Identifiers

Hospitals are asked to provide ForwardHealth with all subpart NPIs (National Provider Identifiers) they use with other payers, including Medicare. Providers are required to provide ForwardHealth with only those subpart NPIs that represent hospital units that are not separately enrolled with Wisconsin Medicaid. ForwardHealth uses subpart NPIs as additional identifiers that are linked to the hospital's enrollment.

Once a subpart NPI is on file with Wisconsin Medicaid, a hospital provider may use the subpart NPI as the billing provider on claims. On adjustments, providers are reminded that the billing provider NPI on the original claim and the billing provider NPI on the adjustment must match.

Providers may add or revise subpart NPI information on file with ForwardHealth using the demographic maintenance tool. In addition to subpart NPIs, providers may add to or revise the taxonomy codes corresponding to the subpart using the demographic maintenance tool.

Subpart NPIs on file with ForwardHealth may be used on claim transactions, PA (prior authorization) requests, WiCall, enrollment verification, provider enrollment, Provider Services inquiries, and the Portal.

Topic #5096

# Taxonomy Codes

Taxonomy codes are standard code sets used to provide information about provider type and specialty for the provider's enrollment. ForwardHealth uses taxonomy codes as additional data for correctly matching the NPI (National Provider Identifier) to the provider file.

Providers are required to use a taxonomy code when the NPI reported to ForwardHealth corresponds to multiple enrollments and the provider's practice location ZIP+4 code does not uniquely identify the provider.

Providers are allowed to report multiple taxonomy codes to ForwardHealth as long as the codes accurately describe the provider type and specialty for the provider's enrollment. When doing business with ForwardHealth, providers may use any one of the reported codes. Providers who report multiple taxonomy codes will be required to designate one of the codes as the primary taxonomy code; ForwardHealth will use this primary code for identification purposes.

Providers who wish to change their taxonomy code or add additional taxonomy codes may do so using the demographic maintenance tool. 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.

# Covered and Noncovered Services

# 2

**Archive Date:04/01/2024**

# Covered and Noncovered Services: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 the NEMT (non-emergency medical transportation) manager contracted with the Wisconsin DHS (Department of Health Services). Most Medicaid and BadgerCare Plus members may receive NEMT services through the NEMT manager 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

Topic #16977

# Noncovered Genetic Testing

Wisconsin Medicaid and BadgerCare Plus do not cover genetic testing in situations where the results would not have a clinically useful impact on health outcomes.

Wisconsin Medicaid and BadgerCare Plus do not cover full genome and exome sequencing.

Topic #17958

# Noncovered Testing for Drugs of Abuse Services

ForwardHealth does not cover the following:

- Any drug test performed without a specific order. Routine, nonspecific, wholesale, standing, or blanket orders for drug tests are not covered.
- Drug testing solely for legal purposes (e.g., court-ordered drug screening) or for employment purposes (e.g., as a pre-requisite for employment or as a requirement for continuation of employment).
- Reflex testing. Reflex tests are definitive drug tests that are performed automatically by a laboratory following a presumptive drug test; they are not based on a specific order.
- Definitive drug tests when a presumptive drug test result (positive or negative) is consistent with a member's self-report, presentation, medical history, and current prescriptions and when definitive drug testing is not necessary to further guide treatment.
- Presumptive drug tests when a direct-to-definitive drug test is performed.

In all cases, providers should only test for drugs or drug classes likely to be present based on the member's medical history, current clinical presentation, and illicit drugs that are in common use. In other words, it is **not** medically necessary or reasonable to routinely test for substances (licit or illicit) that are not used in a member's treatment population or, in the instance of illicit drugs, in the community at large.

## Services Not Separately Reimbursable

Separate reimbursement is not available for the following circumstances:

- Testing of two different specimen types from the same member on the same DOS (date of service), regardless of the number of providers performing the tests
- More than one presumptive or definitive drug test performed per member per DOS, regardless of the number of providers performing the tests

# Codes

Topic #17537

## Cellular/Tissue-Based Products

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

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

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

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

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

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

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

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

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

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

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

Topic #4012

# Cochlear Implants

The following are allowable procedure codes for cochlear implant devices and cochlear implant device repairs and replacements. These procedure codes are separately reimbursable for members residing in a nursing home.

The DME (Durable Medical Equipment) Index lists the maximum allowable fees for the following procedure codes.

| **Cochlear Implant Devices** | |
|---|---|
| **Code** | **Description** |
| L7510 | Repair of prosthetic device, repair or replace minor parts |
| L8614 | Cochlear device, includes all internal and external components |
| L8615 | Headset/headpiece for use with cochlear implant device, replacement |
| L8616 | Microphone for use with cochlear implant device, replacement |
| L8617 | Transmitting coil for use with cochlear implant device or auditory osseointegrated device, replacement |
| L8618 | Transmitter cable for use with cochlear implant device, replacement |
| L8619 | Cochlear implant, external speech processor and controller, integrated system, replacement |
| L8621 | Zinc air battery for use with cochlear implant device, replacement, each |
| L8622 | Alkaline battery for use with cochlear implant device, any size, replacement, each |

| | |
|---|---|
| L8623 | Lithium ion battery for use with cochlear implant device speech processor; other than ear level, replacement, each |
| L8624 | Lithium ion battery for use with cochlear implant or auditory osseointegrated device speech processor, ear level, replacement, each |
| L8625 | External recharging system for battery for use with cochlear implant or auditory osseointegrated device, replacement only, each |
| L8627 | Cochlear implant, external speech processor, component, replacement |
| L8628 | Cochlear implant, external controller component, replacement |
| L8629 | Transmitting coil and cable, integrated for use with cochlear implant device, replacement |

## Replacement Parts for Cochlear Implants

The following cochlear implant device replacement parts are reimbursable under procedure code L7510 (Repair of prosthetic device, repair or replace minor parts).

| Cochlear Implant Devices | |
|---|---|
| **Replacement Parts** | **Life Expectancy** |
| Cochlear auxiliary cable adapter | 1 per 3 years |
| Cochlear belt clip | 1 per 3 years |
| Cochlear harness extension adapter | 1 per 3 years |
| Cochlear signal checker | 1 per 3 years |
| Microphone cover | 1 per year |
| Pouch | 1 per year |

Topic #15277

# EAPGs

The EAPG (Enhanced Ambulatory Patient Groups) system assigns an EAPG to applicable details in order to categorize the services for payment. EAPGs will appear in the detail section of the TXT (text) format file of the RA (Remittance Advice) and on the 835 (835 Health Care Claim Payment/Advice) transaction.

## Unassigned Procedures

EAPG 999 identifies services that cannot be assigned to any valid EAPG. For example, EAPG 999 would be given to claim details that lack a HCPCS (Healthcare Common Procedure Coding System) code. Details with EAPG 999 will pay an amount of $0; these services may not be billed back to the member.

## Inpatient-Only Procedures

EAPG 993 identifies certain procedures that Wisconsin Medicaid will not reimburse on an outpatient hospital claim. An outpatient hospital claim containing one of these procedures will be denied in its entirety. This list may be updated periodically.

EAPG 994 identifies procedures that are defined as inpatient- or ASC (ambulatory surgery center)-only but are considered payable as an outpatient hospital procedure by Wisconsin Medicaid.

Topic #13577

# Modifier Codes

Outpatient hospital providers are required to include all modifiers appropriate to the services or procedures being billed on an outpatient claim. Appropriate modifiers are those used in accordance with common coding principles and ForwardHealth policies.

Topic #1365

# Place of Service Code

Providers are required to use POS (place of service) code 22 (On Campus — Outpatient Hospital) when submitting PA (prior authorization) requests for on-campus outpatient hospital services.

Topic #4510

# Procedure Codes

ForwardHealth requires outpatient hospital providers to indicate valid HCPCS (Healthcare Common Procedure Coding System) or CPT (Current Procedural Terminology) codes in addition to revenue codes on outpatient claims (13X). Certain revenue codes are exempt from this requirement.

Outpatient hospital providers should verify the validity of all HCPCS and CPT codes submitted with revenue codes on the UB-04. Claim details that have invalid HCPCS or CPT codes will be denied.

Topic #15297

# Procedures Reimbursable Only as Inpatient Hospital Services

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 Group).

Outpatient hospital providers billing on a UB-04 Claim Form and physician providers billing these services on professional claims (that is, 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.

Policy information for CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) procedure codes is subject to change; providers should refer to the interactive maximum allowable fee schedule for the most current list of allowable procedure codes.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 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 | 22210 | 22212 | 22214 | 22216 | 22220 |
| 22224 | 22318 | 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 |
| 32670 | 32671 | 32672 | 32800 | 32810 | 32815 | 32820 | 32850 | 32851 | 32852 |
| 32853 | 32854 | 32855 | 32856 | 32900 | 32905 | 32906 | 32940 | 32997 | 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 | 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 | 33508 | 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 | 33621 | 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 | 33741 | 33745 | 33746 | 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 | 33891 | 33910 | 33915 | 33916 | 33917 | 33920 | 33922 |
| 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 | 34151 |
| 34401 | 34451 | 34502 | 34830 | 34831 | 34832 | 35001 | 35002 | 35005 | 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 | 35626 | 35631 | 35632 | 35633 |
| 35634 | 35636 | 35637 | 35638 | 35642 | 35645 | 35646 | 35654 | 35663 | 35671 |
| 35691 | 35693 | 35695 | 35870 | 35905 | 35907 | 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 | 43632 | 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 |
| 50236 | 50300 | 50320 | 50323 | 50325 | 50327 | 50328 | 50329 | 50340 | 50360 |
| 50365 | 50370 | 50380 | 50500 | 50520 | 50525 | 50526 | 50540 | 50547 | 50600 |
| 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 | 51865 | 51900 | 51920 | 51925 |
| 51940 | 51960 | 51980 | 54130 | 54135 | 54438 | 55812 | 55862 | 55865 | 56634 |
| 56637 | 56640 | 57305 | 57307 | 58200 | 58240 | 58822 | 58951 | 58952 | 58953 |
| 58954 | 58956 | 59135 | 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 |
| 62005 | 62010 | 62100 | 62115 | 62117 | 62120 | 62121 | 62140 | 62141 | 62142 |
| 62143 | 62145 | 62146 | 62147 | 62148 | 62164 | 62180 | 62190 | 62192 | 62200 |
| 62201 | 63050 | 63051 | 63077 | 63078 | 63085 | 63086 | 63087 | 63088 | 63090 |
| 63091 | 63101 | 63102 | 63103 | 63170 | 63172 | 63173 | 63185 | 63190 | 63194 |
| 63195 | 63196 | 63197 | 63198 | 63199 | 63250 | 63251 | 63252 | 63265 | 63266 |
| 63268 | 63270 | 63271 | 63275 | 63276 | 63277 | 63278 | 63280 | 63281 | 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 | 99184 | 99190 | 99191 | 99192 | 99468 |
| 99469 | 99471 | 99472 | 99475 | 99476 | 99477 | 99478 | 99479 | 99480 | |

Topic #1364

# Revenue Codes

The following is a complete list of allowable revenue codes for institutional claims for outpatient hospital services.

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

Claim Form.

| Policy | Specific Revenue Codes |
|---|---|
| Revenue codes that require a service-specific third digit from the UB-04 Billing Manual | 011X, 012X, 013X, 015X, 016X, 017X, 020X, 021X, 025X, 036X, 051X, 071X, 090X, 091X, 092X, 094X, 096X |
| Revenue codes that require a HCPCS (Healthcare Common Procedure Coding System) or CPT (Current Procedural Terminology) laboratory procedure code for outpatient services in Form Locator 44 of the UB-04 Claim Form | 030X, 031X, 0923, 0925 |
| Revenue codes for dental services | 0512 (Use when providing dental services as part of an outpatient visit.) |
| Revenue codes for vision care services | 0519 (Use when providing vision care services as part of an outpatient visit.) |
| Revenue code for outpatient observation room | 0710 (Use when member is under observation after recovering from ambulatory surgery.) |
| Revenue code for observation hours | 0762 |
| Revenue code for telehealth services | 0780 (Use with HCPCS code Q3014 when submitting claims for telehealth originating site fees.) |
| Revenue codes exempt from member copayment | 0820–0859, 0901, 0918<br><br>Note: Revenue code 0253 is exempt from member copayment on crossover claims. Revenue code 0450 is exempt from copayment for outpatient services. |
| Noncovered revenue codes | 0140–0149, 0180–0189, 0220–0221, 0229, 0294, 0374, 0420–0449, 0547–0548, 0550, 0609, 0624, 0637, 0660–0669, 0670–0679, 0880, 0990–0999 |
| Noncovered revenue codes "Reserved for Future Assignment" | 0599, 0709, 0719, 0749, 0759, 0779, 0789, 0799 |
| Noncovered revenue codes for psychiatric hospitals | 0520, 0529, 0940, 0949 |
| Noncovered revenue codes for general hospitals billing psychiatric or substance abuse services | 0520, 0529, 0940, 0949 |
| Nonbillable revenue codes | **Nonbillable for bill type 011X:** 0100–0101, 0115, 0135, 0155, 0240, 0249, 0253, 0259, 0279, 0291–0293, 0299, 0479, 0530–0531, 0539, 0540–0546, 0549, 0551–0552, 0559, 0570–0572, 0579, 0580–0582, 0589, 0590, 0600–0604, 0650–0657, 0659, 0912–0913, 0960–0964, 0969, 0971–0979, 0981–0989<br><br>**Nonbillable for bill type 013X:** 0180–0240, 0249, 0259, 0279, 0299, 0540–0546, 0549, 0550–0552, 0559, 0570–0572, 0579, 0580–0582, |

| | |
|---|---|
| | 0589, 0590, 0600–0604, 0650–0657, 0659, 0912–0913, 0990–0999 |
| Billable, noncovered revenue code | 0180 |
| Restricted revenue codes | 0110–0114, 0116–0117, 0119 |
| Revenue code for medication checks | 0510 |

The following is a list of revenue codes that are exempt from the requirement to have a corresponding HCPCS or CPT code indicated on institutional claims for outpatient hospital services.

| Policy | Specific Revenue Codes |
|---|---|
| Exempt revenue codes | 0250, 0251, 0252, 0253, 0258, 0270, 0271, 0272, 0276, 0278, 0370, 0500, 0509, 0521, 0522, 0524, 0525, 0527, 0528, 0583, 0660, 0661, 0662, 0663, 0669, 0710, 0762, 0907, 0931, 0932, 0948, 099X, 100X, 210X, 310X |

Topic #643

# Unlisted Procedure Codes

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

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

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

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

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

For most unlisted codes, ForwardHealth requires additional documentation.

## Unlisted Codes That Require Prior Authorization

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

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

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

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

## Unlisted Codes That Do Not Require Prior Authorization

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

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

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

### How to Submit Claims and Related Documentation

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

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

Topic #830

# Valid Codes Required on Claims

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

# Code Validity

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

# Code Specificity for Diagnosis

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

## Covered Services and Requirements

Topic #1362

# Admission for Observation Purposes in a Single Day

In some cases, an outpatient member may be admitted for observation for a portion of a day. Because the member is not admitted as an inpatient, they are not an inpatient.

Topic #13717

# Bone-Anchored Hearing Devices

ForwardHealth covers unilateral bone-anchored hearing device implant surgeries, bilateral bone-anchored hearing device implant surgeries, and bone-anchored hearing device implant surgeries for profound unilateral sensorineural hearing loss with normal hearing in the opposite ear when the following criteria for coverage are met.

*Note:* Providers (such as bone-anchored hearing device manufacturers, outpatient hospitals, ASCs (ambulatory surgery centers), or rendering surgeons) are required to obtain separate Medicaid enrollment as a DME (durable medical equipment) provider before submitting claims for bone-anchored hearing devices.

## Coverage Criteria for Unilateral Bone-Anchored Hearing Device Implant Surgeries

ForwardHealth covers unilateral bone-anchored hearing device implant surgeries if all of the following criteria are met:

- The member is 5 years of age or older at the time of surgery.
- The member has sufficient bone volume and bone quality to support successful fixture placement as determined by the surgeon AND the surgeon determines that the implant can safely be done in a one-step procedure.
- The member has a conductive and/or mixed hearing loss (unilateral or bilateral) with pure-tone average bone-conduction thresholds (measured at 0.5, 1, 2, and 3 kHz) less than or equal to 65 dB HL. The threshold range is intended to accommodate different degrees of hearing loss and corresponding output power of the bone-anchored hearing device.
- The member demonstrates an air-bone gap of at least 30 dB in the proposed implant ear.
- The member demonstrates a word recognition score greater than 60 percent via conventional air-conduction speech audiometry using single-syllable words.
- The member has one or more of the following conditions:
  - Severe chronic external otitis or otitis media
  - Chronic draining ear through a tympanic membrane perforation
  - Malformation of the external auditory canal or middle ear
  - Stenosis of the external auditory canal
  - Ossicular discontinuity or erosion that cannot be repaired
  - Chronic dermatologic conditions such as psoriasis of the ear canal
  - Tumors of the external canal and/or tympanic cavity
  - Other conditions in which an air-conduction hearing aid is contraindicated for the ear to be implanted, or where the condition prevents restoration of hearing using a conventional air-conduction hearing aid

## Coverage Criteria for Bilateral Bone-Anchored Hearing Device Implant

## Surgeries

ForwardHealth covers bilateral bone-anchored hearing device implant surgeries if the following criteria are met:

- The member meets the unilateral bone-anchored hearing device criteria noted above for both ears and has symmetrical bone-conduction thresholds between ears. Symmetrical bone-conduction thresholds are defined as less than a 10 dB average difference between ears (measured at 0.5, 1, 2, and 3 kHz), or less than a 15 dB difference at individual frequencies.
- The member presents lifestyle needs that justify the need for binaural hearing via bone conduction.

## Coverage Criteria for Bone-Anchored Hearing Device Implant Surgeries for Profound Unilateral Sensorineural Hearing Loss With Normal Hearing in the Opposite Ear

*Note:* Profound unilateral sensorineural hearing loss with normal hearing in the opposite ear is sometimes referred to as unilateral sensorineural deafness or SSD.

ForwardHealth covers bone-anchored hearing device implant surgeries for profound unilateral sensorineural hearing loss if the following criteria are met:

- The member has normal hearing in one ear, defined as a pure-tone average air-conduction threshold measured at 0.5, 1, 2, and 3 kHz of 20 dB HL or better.
- The member has average air-conduction thresholds measured at 0.5, 1, 2, and 3 kHz in the ear with the sensorineural hearing loss of 90 dB HL or poorer.
- The member is 5 years of age or older at the time of surgery.
- The member has sufficient bone volume and bone quality to support successful fixture placement as determined by the surgeon AND the surgeon determines that the implant can safely be done in a one-step procedure.
- The member is mature enough and otherwise able to give accurate feedback on the effectiveness of the intervention during a trial period.

## Non-Implant Bone-Anchored Hearing Devices

ForwardHealth covers non-implant bone-anchored hearing devices; however, PA (prior authorization) is required.

Topic #1567

# Care Must Be Physician or Dentist Directed

Covered hospital outpatient services must be performed by, or under the direction of, a physician or dentist, and be provided in a licensed hospital facility enrolled under Wis. Admin. Code §§ DHS 105.07 or DHS 105.21.

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 #573

# Cochlear Implant Surgeries

Cochlear implant surgery to improve sensorineural hearing loss is covered by ForwardHealth when the following coverage criteria are met.

## Coverage Criteria

### General Coverage Criteria

ForwardHealth covers unilateral and bilateral cochlear implant surgery if **all** of the following criteria are met:

- Cochlear implant surgery is medically necessary and used to treat bilateral sensorineural hearing loss in adults or unilateral or bilateral sensorineural hearing loss in children under age 21.
- The member is cognitively and psychologically suitable for the implant.
- The member's hearing loss is not due to problems with the auditory nerve or with the central auditory nervous system.
- There are no medical contraindications to implantation, as determined by the cochlear implant team. Contraindications include, but are not limited to:
    - Deafness due to lesions of the eighth cranial (acoustic) nerve, central auditory pathway, or brain stem
    - Active or chronic infections of the external or middle ear and mastoid cavity
    - Tympanic membrane perforation
    - Cochlear ossification that prevents adequate electrode insertion as determined by the treating physician
    - Absence of cochlear development as demonstrated by CT (computed tomography) scans
- There is radiographic evidence of cochlear development as demonstrated by a CT and/or MRI (magnetic resonance imaging) scan.
- The member's state of health permits the surgical procedure, as determined by a physician.
- The ear (right or left) is specified.

### Coverage Criteria for Children

ForwardHealth covers unilateral or bilateral cochlear implant surgery under the following circumstances for children under age 21:

- The family has been properly informed about all aspects of the cochlear implant, including evaluation, surgical, and rehabilitation procedures.
- The member is scheduled to attend a concentrated oral and/or aural rehabilitation program recommended by the cochlear implant team through the Birth to 3 Program, local school, rehabilitation site, etc.
- For children under 12 months of age, a cochlear implant team has documented the medical necessity of implantation, and implantation is not medically contraindicated by current evidence-based research or anatomy development.
- For children 12 to 24 months of age, a cochlear implant team has documented the following:
    - Unilateral or bilateral severe to profound pre- or post-lingual sensorineural hearing loss, defined as a hearing threshold of pure-tone average of 70 dB (decibels) hearing loss or greater at 500 Hz (hertz), 1000 Hz, and 2000 Hz.

  - A lack of progress in the development of auditory skills in conjunction with appropriate binaural amplification and participation in intensive auditory rehabilitation over a three-to-six-month period. Limited benefit from amplification may be quantified by measures including, but not limited to, the Meaningful Auditory Integration Scale or the Early Speech Perception Test.
- For children 24 months of age and older, a cochlear implant team has documented the following:
  - Unilateral or bilateral severe to profound pre- or post-lingual sensorineural hearing loss, defined as a hearing threshold of pure-tone average of 70 dB hearing loss or greater at 500 Hz, 1000 Hz, and 2000 Hz.
  - A lack of progress in the development of auditory skills in conjunction with appropriate binaural amplification and participation in intensive auditory rehabilitation over a three-to-six-month period. Limited benefit from amplification is defined and may be quantified as demonstrated by the following:
    - An aided score of 30 percent or less on the Multisyllabic Lexical Neighborhood Test (MLNT) for children 24 months of age.
    - An aided score of 30 percent or less on the Lexical Neighborhood Test (LNT) for children 25 months to 5 years of age.
    - A test that may vary depending upon the child's cognitive and linguistic skills for children 5 years of age and older.

### Coverage Criteria for Adults

ForwardHealth covers unilateral or bilateral cochlear implantation under the following circumstances for adults ages 21 and older:

- The member has a moderate to profound bilateral sensorineural hearing loss (50 dB or poorer averaged over 500-2000 Hz in the better ear).
- The member demonstrates limited benefit from amplification as defined by test scores of less than 50 percent correct in the best aided listening condition on recorded open-set sentence tests.

## Documentation Requirements

The rendering surgeon must document **all** of the following in the member's medical record:

- Documentation that fully supports the coverage criteria
- Preliminary evaluations, diagnoses, and recommendations from a licensed otologist/otolaryngologist and audiologist that must occur within six months of the proposed implant date, prior to the cochlear implant team evaluation
- A pre-surgical team evaluation by a cochlear implant team, which may include otologists, otolaryngologists, audiologists, and experts from the speech-language pathology, psychology, social work, or deaf education disciplines
- Documentation of the cochlear implant team's current experience with cochlear implantation and with rehabilitation strategies
- Documentation of a post-surgical follow-up plan
- For simultaneous or sequential bilateral cochlear implantation, documentation that a unilateral cochlear implant plus a hearing aid in the other ear will **not** result in a sufficient bilateral hearing benefit (for those members, the hearing loss is to a degree that a hearing aid will not produce the required amplification)
- For placement of a second cochlear implant in the opposite ear requested more than 17 months after the initial implantation, documentation from the cochlear implant team supporting the evidenced-based clinical rationale

## Facilities Must Be Medicaid-Enrolled Durable Medical Equipment Providers

Cochlear implant manufacturers, outpatient hospitals, and ASCs (ambulatory surgery centers) are required to obtain separate Medicaid enrollment as a DME (durable medical equipment) provider before submitting claims for the cochlear implants.

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 #1361

# Dental Services

Outpatient hospitalization for dental services is allowed on an emergency and nonemergency (elective) basis for some dental services. Hospitalization for the express purpose of controlling apprehension is not a Medicaid-covered service. This policy applies to outpatient hospital and ambulatory surgical centers.

Emergency hospitalizations, hospital calls, and emergency outpatient dental services (emergency room and day surgery) do not require PA (prior authorization). All elective nonemergency dental procedures require PA if they require PA in other POS (places of service). It is the responsibility of the dentist, not the hospital, to obtain PA.

Wisconsin Medicaid reimburses hospitals providing outpatient dental services under the EAPG (Enhanced Ambulatory Patient Groups) system used for other outpatient hospital services. Outpatient dental procedures, including sedation, are eligible for an additional add-on payment when billed by the hospital using CPT (Current Procedural Terminology) code 41899 (Unlisted procedure, dentoalveolar structures) and modifier U2.

Topic #1360

# Diagnostic Testing, Laboratory, and Therapeutic Services

Diagnostic testing, laboratory, and therapeutic services are considered outpatient hospital services when provided by a hospital enrolled under Wis. Admin. Code §§ DHS 105.07 or DHS 105.21, ordered by a physician, and the member was present in the hospital for the specimen collection. The member may not be a hospital inpatient.

Claims for laboratory services will not be processed through the EAPG (Enhanced Ambulatory Patient Groups) system. These services will be reimbursed at the lower of the usual and customary charge or the maximum allowable fee.

Outpatient hospitals may receive reimbursement for laboratory services resulting from specimens transferred from a source outside the hospital when the hospital laboratory is separately enrolled as an independent laboratory.

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 #1359

## Emergency Room Services

Emergency room services are considered to be one continuous outpatient visit unless the member is admitted to the hospital and counted in the midnight census. For example, if a member enters an outpatient hospital at 11:30 p.m. on October 20 and leaves on October 21 at 5:30 a.m., Wisconsin Medicaid and BadgerCare Plus will consider the visit to be continuous, even though the member's time spent in the outpatient hospital spans more than one DOS (date of service).

Topic #16957

# Emerging Molecular Pathology and Diagnostic Genetic Testing

## Coverage Policy

Genetic testing is a covered service for Wisconsin Medicaid and BadgerCare Plus members when such testing is part of either routine or targeted clinical screening that has been determined to have a clinically useful impact on health outcomes. Resources used to make these determinations may include guidelines developed and endorsed by entities such as the NCCN (National Comprehensive Cancer Network), the ACMG (American College of Medical Genetics and Genomics), and the ACOG (American Congress of Obstetricians and Gynecologists) where those guidelines are published and are evidence based.

Screening tests requiring PA (prior authorization) will be evaluated individually with regard to their impact on clinical outcomes. Genetic testing is a rapidly evolving science and evidence of clinical utility for many tests is still being established. The maximum allowable fee schedule provides the most current information on coverage of genetic testing codes.

ForwardHealth will consider authorizing these genetic tests on a case-by-case basis when clinical utility for the requested test has been established and in accordance with medical necessity as defined in Wis. Admin. Code § DHS 101.03(96m) and HealthCheck "Other Services" published policy where applicable.

All physicians and other professionals who prescribe, refer, or order services for Wisconsin Medicaid and BadgerCare Plus members are required to be Medicaid-enrolled.

### Clinically Useful Criteria

Wisconsin Medicaid and BadgerCare Plus consider genetic testing medically necessary when the testing yields results that can be used specifically to develop a clinically useful approach or course of treatment or to cease unnecessary treatments or monitoring. Clinically useful tests allow providers to treat current symptoms significantly affecting a member's health or to manage the treatable progression of an established disease.

Tests will not be reimbursable for Wisconsin Medicaid and BadgerCare Plus members if the sole outcome would be labeling the disorder or categorizing symptoms that cannot or should not be treated.

### Documentation

All providers who receive payment from Wisconsin Medicaid, including state-contracted 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). Records should clearly support the services rendered and the procedure codes being submitted on claims.

### PA

Wisconsin Medicaid and BadgerCare Plus require PA for some genetic testing in order for the testing to be covered. This requirement is in addition to meeting all other program requirements for covered services.

### Genetic Counseling Requirement

The provider ordering the testing is required to either be, or arrange for consultation with, a provider who has relevant education or training in genetics, such as a genetics counselor, a geneticist, or a physician/nurse practitioner specialist with knowledge of the genetic factors of disease within his or her specialty and the genetic testing process.

Providers who provide genetic counseling should supply the following:

- Interpretation of the patient and family medical histories to assess the chance of disease occurrence
- Education about inheritance, testing, management, prevention, and resources
- Discussion of the ethical, legal, and psychosocial aspects of genetic testing
- Support to make informed decisions

Physicians or APNPs (advanced practice nurse prescribers) who provide counseling should follow CPT (Current Procedural Terminology) guidelines, reporting E&M (evaluation and management) codes on professional claims as appropriate.

## Guidelines for Breast Cancer Susceptibility Gene Testing (Excluding Familial Variant Testing)

BRCA (breast cancer susceptibility gene) 1 and 2 testing requires PA. The PA requests will be adjudicated by Wisconsin Medicaid and BadgerCare Plus according to the guidelines established by the NCCN. Wisconsin Medicaid and BadgerCare Plus require PA for all BRCA tests except familial variant testing.

## Documentation Requirements for Genetic Testing Services Not Requiring PA

Wisconsin Medicaid and BadgerCare Plus do not require PA for the following tests, but the rendering provider is required to keep documentation that applicable criteria are met. In addition to test-specific criteria, genetic counseling prior to testing and informed patient choice must be documented in the ordering provider's clinical record.

### Familial Variants

Some genetic tests focus on known familial variants within a patient's family that may relate to an increased risk of disease or disorder. The laboratory must be provided with a copy of the official laboratory results on a family member showing the variant in order for a laboratory to conduct these tests. For covered familial variant testing identified by individualized CPT procedure codes, Wisconsin Medicaid and BadgerCare Plus consider the family member's result with the variant as adequate evidence of the medical necessity of the test, and PA is not required. Documentation of the family member's result is required to be maintained by the laboratory, but providers are not required to submit those results along with the claim for familial variant testing.

### Fetal Aneuploidy Testing Using Cell-Free Fetal Deoxyribonucleic Acid

Wisconsin Medicaid and BadgerCare Plus cover fetal aneuploidy testing using cell-free fetal DNA in maternal blood tests without

PA in cases that meet the guidelines published by the ACOG (American Congress of Obstetricians and Gynecologists). DNA (deoxyribonucleic acid)-based noninvasive prenatal tests of fetal aneuploidy are proven and medically necessary as screening tools for trisomy 21 (Down syndrome), trisomy 18 (Edwards syndrome), and trisomy 13 (Patau syndrome).

The use of expanded noninvasive prenatal testing panels, which includes additional testing for some micro-deletion syndromes, is not reimbursable.

### Other Tests Allowed Based on ACMG Guidelines

Wisconsin Medicaid and BadgerCare Plus cover the following tests without PA, in cases which meet guideline criteria published by the ACMG:

- Cytogenomic constitutional (genome-wide) microarray analysis
- FMR1 (fragile X mental retardation 1) gene analysis for Fragile X syndrome
- GJB2 (gap junction protein beta 2, connexin 26) gene analysis for nonsyndromic hearing loss

Documentation must be maintained by the provider that demonstrates adherence to ACMG guidelines.

### Panel Versus Component Coding

In adherence with correct coding guidelines, it is not appropriate to report two or more procedures to describe a service when a single, comprehensive procedure exists that more accurately describes the complete service performed by a provider. ForwardHealth expects providers who perform all components of a genomic sequencing procedure and other molecular multianalyte assays to request PA and submit claims only for the associated panel code.

## Reporting Tier 2 and Unlisted Molecular Pathology Codes

Within the CPT procedure code set reserved for molecular pathology is a group of Tier 2 molecular pathology codes that cover a wide range of specific tests based upon the complexity of those tests. Both ordering providers and performing laboratories are required to use CPT procedure codes 81400-81408 only for the tests specifically listed in the descriptions of those codes. If a particular test does not have a specific Tier 1 code and is not listed in the description of any Tier 2 code, providers are required to use CPT procedure code 81479 (Unlisted molecular pathology procedure). PA is required for all Tier 2 molecular pathology codes.

Topic #1358

# End-Stage Renal Disease Services

With the exception of a limited number of emergency dialysis treatments, hospital providers are required to be separately enrolled as a Medicaid ESRD (end-stage renal disease) provider with a specialty of "hospital affiliated" to receive reimbursement for renal disease-related services provided to a member enrolled in BadgerCare Plus or Medicaid.

Hospitals submitting claims under their hospital enrollment (not under ESRD provider enrollment) may receive reimbursement for providing up to three emergency dialysis treatments for a member, per calendar year. Claims received for renal related services beyond this limit will be denied. These dialysis treatments are meant for emergency services only and not for a member with chronic renal failure.

Topic #1395

# Inpatient Status

A member is considered an inpatient when the member is admitted to the hospital as an inpatient and is counted in the midnight census. If a member is admitted to the hospital but is discharged before being counted in the midnight census, the member is considered an outpatient.

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

Topic #22917

# Interpretive Services

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

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

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

## Covered Interpretive Services

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

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

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

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

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

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

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

### Documentation

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

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

### Third-Party Vendors and In-House Interpreters

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

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

### Limitations

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

## Claims Submission

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

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

## Noncovered Services

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

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

procedure code T1013

### Cancellations or No Shows

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

## Procedure Code and Modifiers

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

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

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

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

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

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

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

| Delivery Method of Interpretive Services | Definition for Sign Language and Foreign Language Interpreters | Modifiers |
|---|---|---|
| **In person**<br>(foreign language and sign language) | When the interpreter is physically present with the member and provider | U1 or U3 |
| **Telehealth***<br>(foreign language and sign language) | When the member is located at an originating site and the interpreter is available remotely (via audio-visual or audio only) at a distant site | U1 or U3<br>**and**<br>GT or 93 |

| | | | |
|---|---|---|---|
| | **Phone** (foreign language only) | When the interpreter is not physically present with the member and the provider and interprets via audio-only through the phone | U1 **and** 93 |
| | **Interactive video** (foreign language and sign language) | When the interpreter is not physically present with the member and the provider and interprets on interactive video | U1 or U3<br>**and**<br>GT |

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

### Dental Providers

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

## Allowable Places of Service

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

### Federally Qualified Health Centers

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

### Rural Health Clinics

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

## Interpreter Qualifications

The two types of allowable interpreters include:

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

### Qualifications for Sign Language Interpreters

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

### Qualifications for Foreign Language Interpreters

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

A competent foreign language interpreter should:

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

Topic #17937

# Low-Dose Computed Tomography Scans

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

ForwardHealth requires PA for coverage of all other CT scans, including those that would be performed as a follow up to the initial low-dose CT screening, unless the provider has an exemption under ForwardHealth's advanced imaging PA exemption program.

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

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

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

Topic #1356

# Maternity Stays

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

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 #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 #17677

# Observation Policy

Observation care is defined as a set of specific, clinically appropriate services, including ongoing short-term treatment, assessment, and reassessment, that are performed before determining whether a patient will require inpatient treatment or can be dismissed from the hospital. Observation services are commonly ordered for patients who present to the emergency department and require a significant period of treatment or monitoring, typically a minimum of eight hours, to determine whether to admit or dismiss them.

Observation services are covered only when provided by the order of a physician or another individual authorized by Wisconsin Medicaid to admit patients to the hospital or to order outpatient tests. Following resolution of the reason for the observation care, the decision of whether to dismiss a patient from the hospital or to admit the patient can typically be made in less than 48 hours and is usually made in less than 24 hours.

In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours, as referenced in the Claims Denials and Resubmissions section below.

ForwardHealth allows up to 48 hours of hospital observation, regardless of whether a member is released without being admitted to the hospital or is subsequently admitted as an inpatient and counted in the midnight census.

If, after observation, a member is released without being admitted to the hospital, the outpatient hospital services provided during observation must be indicated as outpatient hospital services on an institutional claim. If, after observation, a member is subsequently admitted to the hospital and is counted in the midnight census, the outpatient hospital services provided during observation as well as the subsequent inpatient hospital services must be billed together on one institutional claim. In this case, the outpatient hospital services are not separately reimbursable.

## Claim Denials and Resubmissions

In limited extenuating circumstances, ForwardHealth will allow up to 72 hours of observation-level services. These circumstances are confined to:

- Chapter holds, otherwise known as emergency detention
- Diseases related to public health emergencies, including suspected cases

For claims that meet the extenuating circumstance criteria listed above and are submitted for 49–72 hours, providers may submit the claim via paper to ForwardHealth with the Written Correspondence Inquiry (F-01170 (07/2012)) form, F-01170 (07/2012), and documentation that identifies the circumstance as a chapter hold and/or a disease related to a public health emergency. Claims submitted without proper documentation for observation lasting more than 48 hours will be automatically denied by ForwardHealth.

On the Written Correspondence Inquiry form, providers should check the Other box in the Reason for Inquiry field and indicate "Request for review of medical necessity for extended observation period" in the space provided. Providers should follow the instructions on the form for submitting the claim, medical documentation, and form to ForwardHealth. A copy of the claim, medical documentation, and form should be retained by providers for their records.

All claims submitted for over 72 hours of observation will be denied.

Topic #11097

# Opioid Monthly Prescription Fill Limit

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

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

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

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

## Prescriber Responsibilities

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

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

- The prescriber's name and NPI (National Provider Identifier)
- The member's name and ID
- The pharmacy's name and phone number where the member attempted to have the prescription filled

- The member's recent medication history
- The member's current opioid prescription information and if a policy override is medically necessary

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

## Pharmacy Responsibilities

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

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

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

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

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

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

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

## Schedule III and IV Drugs

If the prescriber is unavailable, the DAPO Center will grant a 96-hour supply exception to exceed the opioid monthly prescription fill limit for a Schedule III or IV drug if all of the following conditions are met:

- The pharmacy attempted to contact the prescriber (or the prescriber's designee) but the prescriber is unavailable (for example, the clinic is closed).
- The pharmacy staff must document on the prescription order that the prescriber is not available.
- The pharmacist determined that dispensing a 96-hour supply is medically necessary.
- An exception was not previously granted within the current calendar month.

If the prescriber is unavailable and the DAPO Center is closed, then pharmacy providers may dispense an exception if all of the following conditions are met:

- The pharmacy attempted to contact the prescriber (or the prescriber's designee), but the prescriber is unavailable (for example, the clinic is closed).
- The pharmacy staff must document on the prescription order that the prescriber is not available.
- The pharmacist determined that dispensing a 96-hour supply is medically necessary.

- An exception was not previously granted within the current calendar month; however, if the pharmacy was not aware of a previous exception within the current calendar month and dispensed the medication in good faith while the DAPO Center was closed, an override may be approved.

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

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

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

## Schedule II Drugs

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

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

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

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

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

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

Topic #1363

# Outpatient Services Requirements

In accordance with Wis. Admin. Code § DHS 107.08(3)(b), hospitals providing outpatient hospital services are required to meet the same requirements that apply to Medicaid-enrolled, nonhospital providers performing the same services. Outpatient services performed outside the hospital facility are not reimbursed as hospital outpatient services.

Outpatient services must meet all of the following criteria:

- The care is directed by a physician or dentist.
- The care is medically necessary.
- The member is not an inpatient.
- The service is provided in a licensed hospital facility.

Topic #1354

# Outpatient Status

On any given calendar day, a patient in a hospital may be either an inpatient or an outpatient, but not both. Covered outpatient hospital services are those services provided for a member who is not a hospital inpatient.

A member who is admitted as an inpatient and counted in the midnight census is considered an inpatient. If a member has not been officially admitted to the hospital as an inpatient and counted in the midnight census, the member is considered an outpatient. Wisconsin Medicaid considers all covered outpatient services provided during one calendar day as one outpatient visit.

## Continuous Visit Policy

ForwardHealth considers an outpatient visit that spans more than one continuous DOS to be part of a single, continuous visit. For continuous visits, ForwardHealth will pay one per diem and, if applicable, one access payment per visit.

### Multiple Unrelated Visits on the Same Date of Service

ForwardHealth defines a related visit as one whose primary diagnosis matches the primary diagnosis of a subsequent visit. When billing one or more separate, **unrelated** visits that occur on the same DOS as an outpatient continuous visit, ForwardHealth recommends providers submit separate claims for each visit and include condition code G0 (the letter G and the digit zero) on the second claim submitted.

For example, a member comes in to the ER on the morning of January 8, 2013, with a concussion and returns home once treated. He returns to the ER later that same night with a high fever and vomiting and is kept over midnight for observation. In this situation, the provider is encouraged to bill the two visits on two separate claims and to differentiate the visits using condition code G0 on the second claim submitted. This allows ForwardHealth to reimburse both visits and pay two access payments to the provider, if applicable.

Topic #23237

# Over-the-Counter Contraception Standing Orders

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

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

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

## Over-the-Counter Emergency Contraception—Levonorgestrel

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

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

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

# Information for Medicaid Pharmacy Providers

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

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

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

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

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

## Levonorgestrel

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

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

## Opill (Norgestrel)

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

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

# Requirements for a Valid Prescription

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

Topic #1357

# Overlapping Inpatient and Outpatient Services

## Inpatient and Outpatient Services Provided on the Same Date of Service

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

## Outpatient Services Provided to an Inpatient in Another Hospital

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

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 #23037

# Qualifying Clinical Trials

ForwardHealth covers routine services for members participating in qualifying clinical trials. A qualifying clinical trial is defined as a trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition.

Qualifying clinical trials must be at least one of the following:

- A study or investigation that is approved, conducted, or supported (including funding by in-kind contributions) by one or more of the following, or a cooperative group of any of these entities:
  - The NIH (National Institutes of Health)
  - The CDC (Centers for Disease Control and Prevention)
  - Agency for Health Care Research and Quality
  - The CMS (Centers for Medicare & Medicaid Services)
  - The DOD (Department of Defense)
  - The VA (Department of Veterans Affairs)
  - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants

- A clinical trial approved or funded by any of the following entities that has been reviewed and approved through a system of peer review in compliance with section 210 of the Consolidated Appropriations Act:
  - The Department of Energy
  - The VA

    - The DOD

- A clinical trial conducted pursuant to an investigational new drug exemption under section 505(i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under section 351(a)(3) of the Public Health Service Act
- A clinical trial that is a drug trial exempt from the requirements of the investigational new drug exemption under section 505 (i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under section 351(a)(3) of the Public Health Service Act

## Coverage Requirements for Routine Services Associated With Qualifying Clinical Trials

ForwardHealth covers routine services associated with qualifying clinical trials. Routine services include the following:

- Any item or service provided to members participating in a qualifying clinical trial that would otherwise be covered by ForwardHealth (such as otherwise covered physician, laboratory, or medical imaging services)
- Any item or service required solely for the provision of the investigational item or service that is the subject of the qualifying clinical trial (such as administration of the investigational item or service and routine services for the delivery of experimental agents)

Covered items and services must:

- Prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial.
- Be covered outside of participation in the qualifying clinical trial.

## Attestation of Appropriateness of Clinical Trial

In order to cover routine services associated with a clinical trial, ForwardHealth also requires providers to attest to the appropriateness of the qualifying clinical trial. To meet this requirement, the provider and the principal investigator must complete and maintain the CMS attestation form in the member's health care records.

## Coverage Limitations for Clinical Trials

Examples of items and services not covered by ForwardHealth as part of a qualifying clinical trial include the following:

- Any investigational item or service that is the subject of the qualifying clinical trial and is not otherwise covered by ForwardHealth outside of the clinical trial
- Any item or service that is provided to the member solely to satisfy data collection and analysis for the qualifying clinical trial that is not used in the direct clinical management of the member and is not otherwise covered by ForwardHealth outside of the clinical trial

## Prior Authorization Requirements

ForwardHealth requires PA (prior authorization) for coverage of certain procedures or services; this could include certain items or services associated with a clinical trial. The interactive maximum allowable fee schedules include information regarding which procedures/services require PA.

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 #1566

# Substance Abuse and Mental Health Outpatient Clinic Services

Providers may submit claims for substance abuse and mental health outpatient clinic services on the UB-04 Claim Form only if the services are performed within the licensed hospital facility. Mental health and substance abuse programs must obtain certification from the DQA (Division of Quality Assurance) before they can be enrolled as Medicaid programs.

Topic #17959

# Testing for Drugs of Abuse

## Covered Services

Providers are required to use HCPCS (Healthcare Common Procedure Coding System) Level I and Level II procedure codes 80305–80307, G0480–G0483, and code G0659 when submitting claims for testing for drugs of abuse. Codes 80305–80307, G0480–G0483, and G0659 consist of two primary categories of drug testing: presumptive and definitive. Presumptive drug tests are used to detect the presence or absence of a drug or drug class; they do not typically indicate a specific level of drug but rather give a positive or negative result. A presumptive drug test may be followed with a definitive drug test in order to identify specific drugs or metabolites. Definitive drug tests are qualitative or quantitative tests used to identify specific drugs, specific drug concentrations, and associated metabolites.

### Presumptive Drug Tests

ForwardHealth covers medically necessary presumptive drug tests for the following clinical indications:

- Suspected drug overdose, unreliable medical history, and an acute medically necessary situation. Medically necessary situations include, but are not limited to, unexplained coma, unexplained altered mental status, severe or unexplained cardiovascular instability, undefined toxic syndrome, and seizures with an undetermined history.
- Monitoring of a member's compliance during treatment for substance abuse or dependence. This applies to testing during an initial assessment, as well as ongoing monitoring of drug and alcohol compliance. Decisions about which substances to

screen for should be well documented and should be based on the following:
  - The member's history of past drug use or abuse, the results of any physical examinations, and any of the member's previous laboratory findings
  - The substance the member is suspected of misusing
  - The member's prescribed medication(s)
  - Substances that may present high risk for additive or synergistic interactions with the member's prescribed medication(s)
  - Local information about substances commonly abused and misused, such as input from the Substance Abuse and Mental Health Services Administration's Drug Abuse Warning Network that compiles prevalence data on drug-related emergency department visits and deaths
- Monitoring of a member receiving COT (chronic opioid therapy). Decisions about which substances to screen for should be well documented and should be based on the following:
  - The member's history of past drug use or abuse, the results of any physical examinations, and any of the member's previous laboratory findings
  - The member's current treatment plan
  - The member's prescribed medication(s)
  - The member's risk assessment plan

### Definitive Drug Tests

Definitive drug tests can be used to evaluate presumptive drug test results, which can minimize the potential for a clinician to rely on a false negative or false positive result. Definitive drug tests can also be used to guide treatment when it is necessary to identify a specific drug within a drug class or identify a specific concentration of a drug. A definitive drug test order must be medically necessary and reasonable. The order for a definitive drug test must describe the medical necessity for each drug class being tested. A member's self-report may reduce the need for a definitive drug test.

Definitive drug testing includes direct-to-definitive drug tests. Direct-to-definitive drug tests are tests that are used without first performing a presumptive drug test of the sample. Direct-to-definitive drug tests are used when presumptive drug tests do not adequately detect the substance or metabolite identified for testing. Presumptive drug tests are inadequate when the component for a particular drug class does not react sufficiently to the identified drug or drug metabolite within that drug class, resulting in a false negative. Synthetic opioids, some benzodiazepines, or other synthetic drugs may not be adequately detected by presumptive drug tests. Direct-to-definitive drug tests are only appropriate in rare circumstances.

ForwardHealth covers medically necessary definitive drug tests for members when at least one of the clinical indications for presumptive drug tests applies and when there is at least one of the following needs:

- A definitive concentration of a drug must be identified to guide treatment.
- A specific drug in a large family of drugs (e.g., benzodiazepines, barbiturates, and opiates) must be identified to guide treatment.
- A false result must be ruled out for a presumptive drug test that is inconsistent with a member's self-report, presentation, medical history, or current prescriptions.
- A specific substance or metabolite that is inadequately detected by presumptive drug testing (direct-to-definitive testing), as determined on a case-by-case basis in accordance with community standard guidelines set by the practice, must be identified.

## Testing Frequency

Testing for drugs of abuse should not be performed more frequently than the standard of care for a particular clinical indication. The testing frequency must be medically necessary and documented in the member's medical record.

### Acute Medical Testing

A single presumptive and/or definitive drug test is appropriate for any acute medical presentation.

### Chronic Opioid Therapy

Providers are required to document the testing frequency and rationale for testing (including a validated risk assessment) for members receiving COT. The following testing frequencies are based on a member's risk for abuse:

- Members with low risk for abuse may be tested up to one to two times per year.
- Members with moderate risk for abuse may be tested up to one to two times every six months.
- Members with high risk for abuse may be tested up to one to three times every three months.

## Selection of Drug/Drug Class for Testing

In all cases, providers should only test for drugs or drug classes likely to be present based on the member's medical history, current clinical presentation, and illicit drugs that are in common use. In other words, it is **not** medically necessary or reasonable to routinely test for substances (licit or illicit) that are not used in a member's treatment population or, in the instance of illicit drugs, in the community at large.

## Procedure Codes

Providers are required to use procedure codes 80305–80307, G0480–G0483, and G0659 when submitting claims for testing for drugs of abuse. Providers should use procedure codes 80305–80307 when submitting claims for presumptive drug tests. Providers are required to select the appropriate code based on the type of presumptive drug test used.

When submitting claims for definitive drug tests, providers should use procedure codes G0480–G0483 or G0659. Code G0659 should be submitted when a simple definitive drug test(s) is performed (refer to HCPCS for the definition of a simple definitive drug test). Definitive drug testing for more than seven drug classes (using procedure codes G0481–G0483) is only appropriate in rare circumstances.

Providers are required to select the appropriate code based on the HCPCS code definition.

Only one of the three presumptive drug tests may be submitted per day, per member. Only one of the five definitive drug tests may be submitted per day, per member.

## Claim Submission

Providers should use HCPCS Level I or HCPCS Level II procedure codes and follow CMS (Centers for Medicare and Medicaid Services) guidance in the most recent CLFS (Clinical Laboratory Fee Schedule) Final Rule when submitting claims for drug testing to ForwardHealth. The prescribing/referring/ordering provider is required to be Medicaid-enrolled and to be indicated on the claim form.

## Documentation Requirements

The member's medical record must contain documentation that fully supports the medical necessity for services rendered. This documentation includes, but is not limited to, relevant medical history, physical examination, risk assessment, and results of pertinent diagnostic tests or procedures. The medical record must include the following information:

- A signed and dated member-specific order for each ordered drug test that provides sufficient information to substantiate each testing panel component performed ("standing orders," "custom profiles," or "orders to conduct additional testing as needed" are insufficiently detailed and cannot be used to verify medical necessity)
- A copy of the test results

- Rationale for ordering a definitive drug test for each drug class tested
- If a direct-to-definitive drug test is ordered, documentation supporting the inadequacy of presumptive drug testing

If the provider of the service is not the prescribing/referring/ordering provider, the provider of the service is required to maintain documentation of the lab results and copies of the order for the drug test. The clinical indication/medical necessity for the test must be documented in either the order or the member's medical record.

Topic #1355

# Therapy Services

As a result of 2005 Wisconsin Act 25, the 2005-2007 biennial budget, outpatient hospitals follow the program requirements provided in the Therapies service area when providing PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services. These program requirements include covered services and related limitations, PA (prior authorization), requirements and procedures, claim submission requirements, and reimbursement.

*Note*: PT and OT services provided during an outpatient hospital cardiac rehabilitation clinic visit, with cardiac rehabilitation team monitoring or physician electrocardiographic monitoring also provided, are an exception.

## Physical Therapy and Occupational Therapy Services Provided During Outpatient Hospital Cardiac Rehabilitation Clinic Visits

For a PT or OT service to be considered part of an outpatient hospital cardiac rehabilitation clinic visit, all of the following must be true:

- The PT or OT service is provided as part of a multidisciplinary approach and cannot be separated from the outpatient hospital cardiac rehabilitation clinic visit.
- The visit is provided in a licensed outpatient hospital facility.

### Requirements

When providing a PT or OT service as part of an outpatient hospital cardiac rehabilitation clinic visit, providers should note the following:

- PA is not required.
- The PT or OT service may not be reimbursed separately from the cardiac rehabilitation clinic visit. Claims for cardiac rehabilitation clinic visits may be submitted using the 837I transaction or the paper UB-04 Claim Form and the appropriate cardiac rehabilitation clinic revenue code. Reimbursement for the revenue code includes all medically necessary services that are provided as part of the cardiac rehabilitation clinic visit. Providers should refer to Wis. Admin. Code § DHS 101.03(96m) for the definition of medically necessary.

# Surgery Services

Topic #557

# Abortions

## Coverage Policy

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

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

When submitting a claim to ForwardHealth, physicians are required to attach or upload via the ForwardHealth Portal a completed and signed certification statement attesting to one of the previous circumstances. The optional Abortion Certification Statements (F-01161 (09/2019)) form is available to use in this situation. Providers may develop a form of their own, as long as it includes the same information.

## Covered Services

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

## Coverage of Mifeprex

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

When submitting claims for Mifeprex, providers are required to:

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

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

## Physician Counseling Visits Under Wis. Stat. § 253.10

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

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

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

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

## Services Incidental to a Noncovered Abortion

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

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

Topic #22677

# Coverage Policy for Miscarriage Management

This topic addresses miscarriage management for the spontaneous loss of an intrauterine pregnancy.

## Covered Services

ForwardHealth covers surgical and medical treatments for miscarriage management for the spontaneous loss of an intrauterine pregnancy.

Providers should follow CPT (Current Procedural Terminology) and ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) coding guidance to appropriately report procedure and diagnosis codes related to surgical or medical treatment on the applicable claim form.

## Surgical Management

Surgical intervention is covered when clinically appropriate.

## Medical Management

Medical management may include either the use of both mifepristone and misoprostol or misoprostol alone. Providers are required to document a clinical assessment prior to the administration of these drugs.

### Claim Requirements for Mifepristone and Misoprostol

When submitting claims for mifepristone and/or misoprostol, providers are required to:

- Use HCPCS (Healthcare Common Procedure Coding System) code S0190 (Mifepristone, oral, 200mg) for the first dose of mifepristone, along with the E&M (evaluation and management) code that reflects the service provided. Note: ForwardHealth denies claims when billed with a NDC (National Drug Code).
- Use HCPCS code S0191 (Misoprostol, oral, 200mcg) for the drug given during the first or subsequent visits, along with the E&M code that reflects the service provided.

Modifier U9 (procedure code documented on the claim when delivery is at full term) should be used when billing HCPCS codes S0190 and S0191 to indicate drug(s) administered for miscarriage management.

ForwardHealth does not cover HCPCS code S0199 (Medically induced abortion by oral ingestion of medication including all associated services and supplies [e.g., patient counseling, office visits, confirmation of pregnancy by HCG, ultrasound to confirm the duration of pregnancy, ultrasound to confirm completion of abortion] except drugs). Providers must bill components (for example, ultrasounds and office visits) of services performed separately.

Topic #1350

# Outpatient Surgery

Surgical procedures that are considered by ForwardHealth to be allowed outpatient hospital services are covered only when the members are not admitted as inpatients and are not counted in the midnight census.

Wisconsin Medicaid will not reimburse certain services in an outpatient hospital setting, as ForwardHealth considers them appropriate only when performed in an inpatient hospital or in some cases, an ASC (ambulatory surgery center). An outpatient hospital claim containing one of these services will be denied in its entirety.

Topic #1584

# Sterilizations

## General Requirements

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

Medicaid reimbursement for sterilizations is dependent on providers fulfilling all federal and state requirements and satisfactory completion of a Consent for Sterilization (F-01164 (10/2008)) form. There are no exceptions. Federal and state regulations require the following:

- The member is not an institutionalized individual.
- The member is at least 21 years old on the date the informed written consent is obtained.
- The member gives voluntary informed written consent for sterilization.
- The member is not a mentally incompetent individual. A "mentally incompetent" individual is defined as a person who is

declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purposes, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

- At least 30 days, excluding the consent and surgery dates, but not more than 180 days, must pass between the date of written consent and the sterilization date, except in the case of premature delivery or emergency abdominal surgery if:
  - In the case of premature delivery, the sterilization is performed at the time of premature delivery **and** written informed consent was given at least 30 days before the expected date of delivery **and** at least 72 hours before the premature delivery. The 30 days excludes the consent and surgery dates.
  - The sterilization is performed during emergency abdominal surgery **and** at least 72 hours have passed since the member gave written informed consent for sterilization.

# Consent for Sterilization Form

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

ForwardHealth requires all of the following individuals to sign and date the completed form by hand (electronic signatures will not be accepted):

- The individual to be sterilized.
- The interpreter, if one was provided.
- The person who obtained the consent.
- The physician who performed the sterilization procedure.

If any of the required signatures or initials and dates are missing or incomplete, the form will be considered invalid and will be returned to the provider.

*Note*: ForwardHealth allows the use of off-site interpreters (using video technology or telephone) for assistance in the completion of this form. The off-site interpreter is required to sign and date the form by hand (electronic signatures will not be accepted, and the interpreter's ID number does not fulfill this requirement). A copy of the completed form can be sent to the off-site interpreter for his or her signature and then faxed back to the provider.

Providers' failure to comply with any of the sterilization requirements results in denial of the sterilization claims.

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

# Telehealth

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Topic #22737

# Behavioral Health Telehealth Services

Behavioral health services should be indicated by the following modifiers.

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

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

Topic #22738

# Interprofessional Consultations (E-Consults)

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

## Policy Requirements and Limitations

### Consulting Providers

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

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

### Treating Providers

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

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

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

## Documentation Requirements

The following documentation requirements apply for e-consults:

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

Topic #22739

# Originating and Distant Sites

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

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

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

## Claims Submission and Reimbursement for Distant Site Providers

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

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

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

### Ancillary Providers

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

Refer to the Supervision topic for additional information.

### Pediatric and Health Professional Shortage Area-Eligible Services

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

## Claims Submission and Reimbursement for Originating Site Fee

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

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

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

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

To receive reimbursement, the originating site must:

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

### Federally Qualified Health Centers and Rural Health Clinics

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

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

**Distant Site**

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

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

**Originating Site**

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

Topic #22740

# Remote Patient Monitoring

## Remote Physiologic Monitoring

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

### Eligible Devices

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

### Policy Requirements

The following policy requirements apply for remote physiologic monitoring services:

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

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

Providers are expected to follow CPT guidelines.

### Claim Submission

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

Topic #22757

# Supervision

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

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

## Supervision of Paraprofessional Providers

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

## Personal Care/Home Health Provider Supervision

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

## Direct Supervision for Ancillary Care Providers

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

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

## Supervision for Behavioral Health Services

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

## Documenting Supervision Method

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

Topic #22837

# Telehealth Definitions

## General Telehealth Definitions

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

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

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

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

## Telehealth Service Definitions

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

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

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

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

Topic #510

# Telehealth Policy

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

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

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

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

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

## Telehealth Policy Requirements

The following requirements apply to the use of telehealth:

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

## Allowable Services

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

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

related services through telecommunication technology.

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

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

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

### Services Not Appropriate Via Telehealth

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

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

### Reimbursement for Covered Services

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

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

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

## Documentation Requirements

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

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

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

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

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

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

## Audio-Only Guidelines

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

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

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

## Member Consent Guidelines for Telehealth

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

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

## Privacy and Security

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

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

### Group Treatment

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

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

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

## Costs Member Cannot Be Billed For

The following cannot be billed to the member:

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

# Allowable Providers

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

# Requirements and Restrictions

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

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

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

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

# Noncovered Services

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

# Additional Policy for Certain Types of Providers

## Out-of-State Providers

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

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

Out-of-state providers who do not have border status enrollment with Wisconsin Medicaid are required to obtain PA before providing services via telehealth to BadgerCare Plus or Medicaid members.

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

Topic #22741

# Telestroke Services

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

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

## Claims Submission for Telestroke Services

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

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

Topic #22742

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

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

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

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

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

| Virtual Check-In Procedure Code | Description |
|---|---|

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

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

| | |
|---|---|
| | time during the seven days; 21 or more minutes |

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

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

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

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

# Telephone Evaluation and Management Services

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

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

# Prior Authorization

## 3

Topic #18057

# Bone-Anchored Hearing Device Repairs and Replacements

HCPCS (Healthcare Common Procedure Coding System) procedure codes L7510 (Repair of prosthetic device, repair or replace minor parts) and L8691 (Auditory osseointegrated device, external sound processor excludes transducer/actuator; replacement only, each) are allowable for repairs and replacements of bone-anchored hearing devices.

PA (prior authorization) is required for procedure code L7510 if the total repair of the bone-anchored hearing device exceeds $150.00 or if the replacement parts of the bone-anchored hearing device have not exceeded their life expectancy.

PA is not required for procedure code L8691.

*Note:* ForwardHealth assigns "U" modifiers to multiple items listed on PA requests to indicate separate approval of DME (durable medical equipment) items (i.e., accessories).

Topic #22820

# Hemgenix

Hemgenix requires clinical PA (prior authorization).

Hemgenix is covered and reimbursed under the pharmacy benefit. Providers should submit claims for Hemgenix to ForwardHealth using a noncompound drug claim. For specific questions about the billing or coverage of high cost, orphan, and accelerated approval drugs, providers may contact Provider Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

## Additional Requirements for Hemgenix

Physician-administered Hemgenix is reimbursed separately from physician and clinical services associated with the administration of Hemgenix. The pharmacy provider is required to establish a delivery process with the prescriber to ensure that physician-administered Hemgenix is delivered directly to the prescriber or an agent of the prescriber. Pharmacy providers may only submit a claim to ForwardHealth for Hemgenix that has been administered to a member. If Hemgenix has been dispensed for a member but the dose is not administered to the member, the prescriber is responsible for notifying the dispensing pharmacy. If ForwardHealth has paid the dispensing pharmacy for any portion of the dispensing of Hemgenix that is not administered to the member, the dispensing pharmacy is responsible for reversing any claims submitted to ForwardHealth.

## Clinical Criteria for Hemgenix

Clinical criteria that must be documented for approval of a PA request for Hemgenix are **all** of the following:

- Hemgenix must be prescribed by a hematologist at a dose of $2 \times 10^{13}$ genome copies (gc) per kilogram of body weight.
- The member has been diagnosed with Hemophilia B (congenital Factor IX deficiency).
- The member is 18 years of age or older.
- The member must currently be treated with Factor IX prophylaxis therapy.

- The member must have a current or historical life-threatening hemorrhage, or have repeated, serious spontaneous bleeding episodes.
- The prescriber must include documentation of Factor IX inhibitor titer testing. In case of a positive test result for human Factor IX inhibitors, perform a re-test within approximately 2 weeks. If both the initial test and re-test results are positive, PA for Hemgenix will not be approved.
- The prescriber must include documentation of liver health assessments including, ALT (alanine transaminase), AST (aspartate aminotransferase), ALP (alkaline phosphatase), total bilirubin, hepatic ultrasound, and hepatic elastography. If the member has radiological liver abnormalities and/or sustained liver enzyme elevations, documentation of a consultation with a hepatologist to assess eligibility for Hemgenix will be required.

Supporting clinical information and a copy of the member's current medical records must be included with all PA requests. The supporting clinical information and the medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

## Submitting PA Requests for Hemgenix

PA requests for Hemgenix must be completed, signed, and dated by the prescriber. PA requests for Hemgenix must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (01/2024)) form. Clinical documentation supporting the use of Hemgenix must be submitted with the PA request.

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

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) to ForwardHealth.

PA requests for Hemgenix may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Topic #21199

# Luxturna

Luxturna requires clinical PA (prior authorization).

Note: The Select High Cost, Orphan, and Accelerated Approval Drugs data table identifies select high cost, orphan, and accelerated approval drugs and interim billing and coverage information for these drugs. The table also identifies which drugs have specific PA or policy requirements. For specific questions about the billing or coverage of high cost, orphan, and accelerated approval drugs listed in the Select High Cost, Orphan, and Accelerated Approval Drugs data table, providers may contact Provider Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

## Clinical Criteria for Luxturna

Clinical criteria that must be documented for approval of a PA request for Luxturna are **all** of the following:

- The member has a confirmed diagnosis of an inherited retinal dystrophy due to biallelic RPE65 mutations.

- The member has sufficient viable retinal cells (defined as an area of retinal thickness greater than 100 microns within the posterior pole) as measured by OCT (optical coherence tomography).
- The member has remaining light perception in the eye(s) that will receive treatment.
- Luxturna is prescribed and administered by an ophthalmologist or retinal surgeon with experience providing subretinal injections.

If clinical criteria for Luxturna are met, PA requests may be approved on a unilateral basis for up to four weeks (one lifetime dose per eye). For consideration of continued therapy on the second eye, **all** of the following must apply:

- All clinical criteria for initial PA request approval must be met.
- Administration is planned within a close interval to the treatment of the first eye, but at least six days apart.
- The PA request is not for a repeat treatment of a previously treated eye.

## Submitting PA Requests for Luxturna

For PA requests for Luxturna, the prescriber is required to complete, sign, and date the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (01/2024)) form, using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the form. The prescriber is required to send the completed PA/DGA form to the pharmacy where the prescription will be filled. The pharmacy provider is required to complete a PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) and submit it, along with the PA/DGA form received from the prescriber, to ForwardHealth using the PA submission option most appropriate for the drug.

PA requests for Luxturna may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Topic #23038

# Qualifying Clinical Trials

The interactive maximum allowable fee schedules include information regarding which procedures/services require PA (prior authorization). If an item or service associated with a clinical trial requires PA, ForwardHealth requires the following information as part of the PA request:

- A completed and signed PA/RF (Prior Authorization Request Form, F-11018 (05/2013))
- A completed and signed PA/PA (Prior Authorization/Physician Attachment, F-11016 (07/2012)) form
- Inclusion of HCPCS (Healthcare Common Procedure Coding System) modifier Q1 (Routine clinical service provided in a clinical research study that is in an approved clinical research study) on the PA forms
- Inclusion of an ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) diagnosis code to indicate the services are associated with a clinical trial, such as Z00.6 (Encounter for examination for normal comparison and control in clinical research program) on the PA forms
- Supporting clinical records documenting the evaluation, the treatment plan, and the appropriateness of member participation in the clinical trial

ForwardHealth will expedite these PA requests.

Topic #23117

# Roctavian

Roctavian requires clinical PA (prior authorization) and is covered under the pharmacy benefit. Pharmacy providers should submit a pharmacy noncompound drug claim for Roctavian.

For questions about the billing or coverage of high cost, orphan, and accelerated approval drugs, providers may contact Provider Services or email dhsorphandrugs@dhs.wisconsin.gov.

# Claim Requirements for Roctavian

Physician-administered Roctavian will be reimbursed separately from physician and clinical services associated with the administration of Roctavian.

The pharmacy provider is required to establish a delivery process with the prescriber to ensure that physician-administered Roctavian is delivered directly to the prescriber or an agent of the prescriber. Pharmacy providers may only submit a claim to ForwardHealth for Roctavian that has been administered to a member. If Roctavian has been dispensed for a member but the dose is not administered to the member, the prescriber is responsible for notifying the dispensing pharmacy. If ForwardHealth has paid the dispensing pharmacy for any portion of the dispensing of Roctavian that is not administered to the member, the dispensing pharmacy is responsible for reversing any claims submitted to ForwardHealth.

# Clinical Criteria for Roctavian

The following clinical criteria that must be documented for approval of a PA request for Roctavian are **all** of the following:

- Roctavian must be prescribed by a hematologist at a dose of 6 x 1013 vector genomes per kilogram of body weight.
- The member is 18 years of age or older.
- The member has been diagnosed with severe hemophilia A (congenital factor VIII deficiency with factor VIII activity less than 1 IU/dL) without pre-existing antibodies to AAV5 (adeno-associated virus serotype 5).
- The prescriber must include documentation of testing for pre-existing antibodies to AAV5 using the FDA (Food and Drug Administration)-approved companion diagnostic. If the companion diagnostic test is positive for antibodies to AAV5, PA for Roctavian will not be approved.
- The prescriber must include documentation of liver health assessments including ALT (alanine aminotransferase), AST (aspartate aminotransferase), GGT (gamma-glutamyl transferase), ALP (alkaline phosphatase), total bilirubin, INR (international normalized ratio), hepatic ultrasound and elastography, or laboratory assessments for liver fibrosis. If the member has radiological liver abnormalities and/or sustained liver enzyme elevations, documentation of a consultation with a hepatologist to assess eligibility for Roctavian will be required.

Supporting clinical information and a copy of the member's current medical records must be included in all PA requests for Roctavian. The supporting clinical information and the medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

## Submitting PA Requests for Roctavian

PA requests for Roctavian must be completed, signed, and dated by the prescriber. PA requests for Roctavian must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (01/2024)) form. Clinical documentation supporting the use of Roctavian must be submitted with the PA request.

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

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF (Prior Authorization Request

Form, F-11018 (05/2013)) to ForwardHealth.

PA requests for Roctavian may be submitted Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Topic #21201

# Select High Cost, Orphan, or Accelerated Approval Drugs

## Prior Authorization Requirements for Select High Cost, Orphan, or Accelerated Approval Drugs

Select high cost, orphan, or accelerated approval drugs may require PA (prior authorization), but in some cases, ForwardHealth will not establish drug-specific clinical criteria. For PA requests for select high cost, orphan, or accelerated approval drugs without drug-specific clinical criteria, the prescriber is required to complete, sign, and date the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (01/2024)) form, using Section VII (Clinical Information for Other Drug Requests) of the form. The prescriber is required to send the completed PA/DGA form to the pharmacy where the prescription will be filled. The pharmacy provider is required to complete a PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) and submit it, along with the PA/DGA form received from the prescriber, to ForwardHealth using the PA submission option most appropriate for the drug.

If a high cost, orphan, or accelerated approval drug requires PA, but drug-specific clinical criteria are not established, PA requests for these drugs require the submission of medical records (for example, chart notes, laboratory values) to support that the drug being prescribed is for an FDA (Food and Drug Administration)-approved indication and is medically necessary as defined by Wis. Admin. Code § DHS 101.03(96m). The drug must be prescribed in a dose and manner consistent with FDA-approved product labeling. These PA requests will be reviewed on a case-by-case basis for medical necessity.

PA requests for these drugs may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Note: For specific questions about the billing or coverage of high cost, orphan, and accelerated approval drugs listed in the Select High Cost, Orphan, and Accelerated Approval Drugs data table, providers may contact Provider Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

### Clinical Criteria for Select High Cost, Orphan, or Accelerated Approval Drugs

The Select High Cost, Orphan, and Accelerated Approval Drugs data table identifies high cost, orphan, and accelerated approval drugs that require PA to support that use will be for an FDA-approved indication; PA requests for these drugs will be reviewed on a case-by-case basis for medical necessity.

As new high cost, orphan, and accelerated approval drugs enter the market, ForwardHealth will use the Select High Cost, Orphan, and Accelerated Approval Drugs data table to identify whether or not these drugs require PA. For drugs that require PA, the table will indicate whether or not the drugs have drug-specific PA clinical criteria.

Topic #1346

# Services Requiring Prior Authorization

For complete information on PA (prior authorization), providers may refer to the following service areas:

- Outpatient Mental Health.
- Outpatient Substance Abuse.
- Therapies: Physical, Occupational, and Speech and Language Pathology.

*Note:* PT (physical therapy), OT (occupational therapy), or SLP (speech and language pathology) evaluations and re-evaluations do not require PA.

Out-of-state nonborder status hospitals providing nonemergency services require PA.

Topic #22097

# Spinal Muscular Atrophy Drugs

Clinical PA (prior authorization) is required for all SMA (spinal muscular atrophy) drugs.

ForwardHealth does not cover treatment with more than one SMA drug at a time. If a member is transitioning treatment from Spinraza to Evrysdi, a waiting period of 90 days from the last injection is required before starting Evrysdi. The member's current approved PA request for Spinraza will be enddated upon approval of Evrysdi. If a member is transitioning treatment from Evrysdi to Spinraza, the member's current approved PA request for Evrysdi will be enddated upon approval of Spinraza. If a member has previously received treatment with Zolgensma, a PA request for another SMA drug treatment will be denied.

## Claims Submission for Spinal Muscular Atrophy Drugs

SMA drugs, including Evrysdi, will be covered and reimbursed under the pharmacy benefit. Providers should submit claims for SMA drugs to ForwardHealth using a noncompound drug claim. For specific questions about the billing or coverage of high cost, orphan, and accelerated approval drugs Sprinraza or Zolgensma, providers may contact Provider Services or email dhsorphandrugs@dhs.wisconsin.gov.

### Additional Requirements for Physician-Administered Spinal Muscular Atrophy Drugs

Physician-administered SMA drugs (for example, Spinraza and Zolgensma) are reimbursed separately from physician and clinical services associated with the administration of the SMA drugs. The pharmacy provider is required to establish a delivery process with the prescriber to ensure that the physician-administered SMA drugs are delivered directly to the prescriber or an agent of the prescriber. Pharmacy providers may only submit a claim to ForwardHealth for the SMA drugs that have been administered to a member. If an SMA drug has been dispensed for a member but the dose is not administered to the member, the prescriber is responsible for notifying the dispensing pharmacy. If ForwardHealth has paid the dispensing pharmacy for any portion of the dispensing of an SMA drug that is not administered to the member, the dispensing pharmacy is responsible for reversing any claims submitted to ForwardHealth.

## Evrysdi

### Clinical Criteria for Evrysdi

The following clinical criteria must be met and documented for approval of a PA request for Evrysdi:

- Evrysdi is prescribed by a neurologist, pulmonologist, or other physician with expertise in treating SMA and in a manner consistent with the FDA (Food and Drug Administration)-approved product labeling.
- The member receives medication counseling prior to initiating Evrysdi treatment, and the provider must comply with administration requirements per FDA labeling. (Medication must be dosed after a meal, patients are instructed to drink water after the dose is administered, and medication must be given within five minutes after it has been drawn up into the oral syringe.)

- The member has SMA type 1, 2, or 3, which has been confirmed by genetic testing (5q SMN1 (survival motor neuron 1): homozygous mutation, homozygous gene deletion, or compound heterozygote).
- The member has **at least two** copies of the SMN2 (survival motor neuron 2) gene.
- The prescriber submits exam values from **at least one** of the following exams (based on member age and motor ability) to establish a baseline motor ability:
  - HINE (Hammersmith Infant Neurological Examination) (infant to early childhood)
  - HFMSE (Hammersmith Functional Motor Scale Expanded)
  - RULM (Revised Upper Limb Module) test (non-ambulatory members)
  - CHOP INTEND (Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders)
  - 6MWT (six-minute walk test) (ambulatory members)
  - MFM32 (Motor Function Measure 32)
- The prescriber indicates the member's pulmonary status, including any requirement for ventilator support.

ForwardHealth will consider coverage for Evrysdi on a case-by-case basis if any of the following circumstances are present for the member:

- Complete paralysis of the limbs
- Ventilator dependent for 16 or more hours per day (including non-invasive respiratory support)

A copy of the member's medical records must be submitted and should sufficiently document:

- The information listed in the clinical criteria for PA approval.
- Details regarding previous medication use.
- The member's current treatment plan.

**ForwardHealth will deny PA requests for Evrysdi if any of the following circumstances are present:**

- The member is currently involved in a clinical trial for an SMA drug.
- The member has received treatment with Zolgensma.
- The member is **currently** receiving treatment with Spinraza.
- The member is diagnosed with a non-SMN1 variant of SMA.

Initial PA requests for Evrysdi to treat SMA may be approved for up to 183 days.

## Renewal PA Requests

In addition to meeting the clinical criteria for initial PA request approval, renewal PA requests for Evrysdi require the submission of medical records (for example, chart notes, assessment of neurological and motor function) with the most recent results (less than two months prior to the submission of the renewal PA request) documenting a positive clinical response to Evrysdi therapy **from pretreatment baseline status** as demonstrated by **one** or more of the following exams:

- HINE that demonstrates the following:
  - Improvement or maintenance of previous improvement of at least a two-point (or maximal score) increase in the ability to kick **or** improvement or maintenance of previous improvement of at least a one-point increase in any other HINE milestone (for example, head control, rolling, sitting, crawling), excluding voluntary grasp
  - Net positive improvement in condition, defined as building on previous improvement from the pretreatment baseline in a majority of the HINE motor milestones **or** achievement or maintenance of any new motor milestone(s) from the pretreatment baseline when the member would otherwise be unexpected to do so (for example, sit unassisted, stand, walk)
- HFMSE that demonstrates **one** of the following:
  - Improvement or maintenance of previous improvement of at least a three-point increase in score from pretreatment baseline
  - Achievement and maintenance of any new motor milestone(s) from pretreatment baseline when the member would

otherwise be unexpected to do so
- RULM test that demonstrates **one** of the following:
    - Improvement or maintenance of previous improvement of at least a two-point increase in score from pretreatment baseline
    - Achievement and maintenance of any new motor milestone(s) from pretreatment baseline when the member would otherwise be unexpected to do so
- CHOP INTEND that demonstrates **one** of the following:
    - Improvement or maintenance of previous improvement of at least a four-point increase in score from pretreatment baseline
    - Achievement and maintenance of any new motor milestone(s) from pretreatment baseline when the member would otherwise be unexpected to do so
- MFM32:
    - Improvement or maintenance of previous improvement of at least a two-point increase in score from pretreatment baseline
    - Achievement and maintenance of any new motor milestone(s) from pretreatment baseline when the member would otherwise be unexpected to do so

Renewal PA requests for Evrysdi used to treat SMA may be approved for up to 365 days.

### Submitting PA Requests for Evrysdi

PA requests for Evrysdi must be submitted using the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (01/2024)) form.

PA requests for Evrysdi must be completed, signed, and dated by the prescriber. PA requests for Evrysdi should be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

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

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) to ForwardHealth.

PA requests for Evrysdi may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

## Spinraza

### Clinical Criteria for Spinraza

The following clinical criteria must be met and documented for approval of a PA request for Spinraza:

- Spinraza is prescribed by a neurologist, pulmonologist, or other physician with expertise in treating SMA and in a manner consistent with the FDA-approved product labeling.
- The member has SMA type 1, 2, or 3, which has been confirmed by genetic testing (5q SMN1: homozygous mutation, homozygous gene deletion, or compound heterozygote).
- The member has **at least two** copies of the SMN2 gene.
- The prescriber submits exam values from **at least one** of the following exams (based on member age and motor ability) to establish a baseline motor ability:
    - HINE (infant to early childhood)
    - HFMSE

    - RULM test (non-ambulatory members)
    - CHOP INTEND
    - 6MWT (ambulatory members)
- The prescriber indicates the member's pulmonary status, including any requirement for ventilator support.

ForwardHealth will consider coverage for Spinraza on a case-by-case basis if any of the following circumstances are present for the member:

- Complete paralysis of the limbs
- Ventilator dependent for 16 or more hours per day (including non-invasive respiratory support)
- Pre-symptomatic infants who have not yet developed symptoms but have undergone genetic studies indicating a high likelihood of developing type 1, 2, or 3 SMA disease (that is, less than three copies of the SMN2 gene)

A copy of the member's medical records must be submitted and should sufficiently document:

- The information listed in the clinical criteria for PA approval.
- Details regarding previous medication use.
- The member's current treatment plan.

**ForwardHealth will deny PA requests for Spinraza if any of the following circumstances are present:**

- The member is currently involved in a clinical trial for an SMA drug.
- The member has received treatment with Zolgensma.
- The member is **currently** receiving treatment with Evrysdi.
- The member is diagnosed with a non-SMN1 variant of SMA.

Initial PA requests for Spinraza to treat SMA may be approved for up to 210 days to allow for up to five doses of Spinraza.

## Renewal PA Requests

In addition to meeting the clinical criteria for initial PA request approval, renewal PA requests for Spinraza require the submission of medical records (for example, chart notes, assessment of neurological and motor function) with the most recent results (less than one month prior to the submission of the renewal PA request) documenting a positive clinical response to Spinraza therapy **from pretreatment baseline status** as demonstrated by **one** or more of the following exams:

- HINE that demonstrates the following:
    - Improvement or maintenance of previous improvement of at least a two-point (or maximal score) increase in the ability to kick **or** improvement or maintenance of previous improvement of at least a one-point increase in any other HINE milestone (for example, head control, rolling, sitting, crawling), excluding voluntary grasp
    - Net positive improvement in condition, defined as building on of previous improvement from the pretreatment baseline in a majority of the HINE motor milestones **or** achievement or maintenance of any new motor milestone(s) from the pretreatment baseline when the member would otherwise be unexpected to do so (for example, sit unassisted, stand, walk)
- HFMSE that demonstrates **one** of the following:
    - Improvement or maintenance of previous improvement of at least a three-point increase in score from pretreatment baseline
    - Achievement and maintenance of any new motor milestone(s) from pretreatment baseline when the member would otherwise be unexpected to do so
- RULM test that demonstrates **one** of the following:
    - Improvement or maintenance of previous improvement of at least a two-point increase in score from pretreatment baseline
    - Achievement and maintenance of any new motor milestone(s) from pretreatment baseline when the member would otherwise be unexpected to do so

- CHOP INTEND that demonstrates **one** of the following:
  - Improvement or maintenance of previous improvement of at least a four-point increase in score from pretreatment baseline
  - Achievement and maintenance of any new motor milestone(s) from pretreatment baseline when the member would otherwise be unexpected to do so

Renewal PA requests for Spinraza used to treat SMA may be approved for up to 365 days.

### Submitting PA Requests for Spinraza

PA requests for Spinraza must be submitted using the PA/DGA form.

PA requests for Spinraza must be completed, signed, and dated by the prescriber. PA requests for Spinraza should be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

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

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for Spinraza may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

## Zolgensma

### Clinical Criteria for Zolgensma

The following clinical criteria must be met and documented for approval of a PA request for Zolgensma:

- Zolgensma is prescribed by a neurologist, pulmonologist, or other physician with expertise in treating SMA and in a manner consistent with the FDA-approved product labeling.
- The member is less than 2 years old.
- The member has SMA, type 1, 2, or 3, which has been confirmed, by genetic testing (5q SMN1: homozygous mutation, homozygous gene deletion, or compound heterozygote).
- The member has **at least two** copies of the SMN2 gene.
- The member does not have advanced SMA including, but not limited to, any of the following:
  - Complete paralysis of the limbs
  - Ventilator dependent for 16 or more hours per day (including non-invasive respiratory support)
- The prescriber submits the most recent pre-treatment anti-AAV9 (adeno-associated virus 9) antibody testing, demonstrating a titer ratio of less than 50 to 1.

A copy of the member's medical records must be submitted and should sufficiently document:

- The information listed in the clinical criteria for PA approval.
- Details regarding previous medication use.
- The member's current treatment plan.

Note: ForwardHealth covers one treatment per lifetime with Zolgensma for pediatric members less than 2 years of age.

**ForwardHealth will deny PA requests for Zolgensma if any of the following circumstances are present:**

- The member is currently involved in a clinical trial for an SMA drug.
- The member has received prior treatment with Zolgensma.
- The member is **currently** receiving treatment with Spinraza or Evrysdi.
  Note: If a member already has a current approved PA request for Spinraza or Evrysdi, ForwardHealth will enddate the Spinraza or Evrysdi PA request upon approval of Zolgensma.
- The member is diagnosed with a non-SMN1 variant of SMA.
- The member is over 2 years of age.

### Submitting PA Requests for Zolgensma

PA requests for Zolgensma must be submitted using the PA/DGA form.

PA requests for Zolgensma must be completed, signed, and dated by the prescriber. PA requests for Zolgensma should be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

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

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for Zolgensma may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Topic #23103

# Vyjuvek

Vyjuvek requires clinical PA (prior authorization) and is covered under the pharmacy benefit. Pharmacy providers should submit a pharmacy noncompound drug claim for Vyjuvek.

For questions about the billing or coverage of high cost, orphan, and accelerated approval drugs, providers may contact Provider Services or email dhsorphandrugs@dhs.wisconsin.gov.

## Claim Requirements for Vyjuvek

Physician-administered Vyjuvek will be reimbursed separately from physician and clinical services associated with the administration of Vyjuvek.

The pharmacy provider is required to establish a delivery process with the prescriber to ensure that physician-administered Vyjuvek is delivered directly to the prescriber, an agent of the prescriber, or a health care provider designated to administer Vyjuvek to the member. Pharmacy providers may only submit a claim to ForwardHealth for the Vyjuvek that has been administered to a member. If Vyjuvek has been dispensed for a member but the dose is not administered to the member, the prescriber or health care provider designated to administer Vyjuvek to the member is responsible for notifying the dispensing pharmacy. If ForwardHealth has paid the dispensing pharmacy for any portion of the dispensing of Vyjuvek that is not administered to the member, the dispensing pharmacy is responsible for reversing any claims submitted to ForwardHealth.

## Clinical Criteria for Vyjuvek

The following clinical criteria must be met and documented for approval of a PA request for Vyjuvek:

- Vyjuvek must be prescribed by a dermatologist or wound care specialist.
- The member is 6 months of age or older.
- The member has been diagnosed with dystrophic epidermolysis bullosa with mutation(s) in the collagen type VII alpha 1 chain gene.
- The prescriber must include documentation of at least one cutaneous wound that is appropriate to be treated with Vyjuvek and confirm that the wound does not appear to be infected.
- The prescriber must include documentation of the size of the wound area(s) to be treated and confirm the calculated dose of Vyjuvek will not exceed the recommended maximum weekly dose.
- The prescriber must include documentation that the member's treatment plan includes the appropriate administration of Vyjuvek by a health care provider and the wound dressing care required for treatment with Vyjuvek.
- The prescriber must include documentation that the member's treatment plan addresses the requirement for Vyjuvek to be properly prepared at a pharmacy for administration to the member?s wound(s) within eight hours of mixing of the Vyjuvek gel with the Vyjuvek biological suspension.

Supporting clinical information and a copy of the member's current medical records must be included in all PA requests for Vyjuvek. The supporting clinical information and the medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

## Submitting PA Requests for Vyjuvek

PA requests for Vyjuvek must be completed, signed, and dated by the prescriber. PA requests for Vyjuvek must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (01/2024)) form. Clinical documentation supporting the use of Vyjuvek must be submitted with the PA request.

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

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) to ForwardHealth.

PA requests for Vyjuvek may be submitted Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

# Advanced Imaging Services

Topic #15477

# Exemption from Prior Authorization

## Providers Ordering Computed Tomography and Magnetic Resonance Imaging Services

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

Note: It is the ordering provider's responsibility to communicate PA status (whether the provider is exempt from PA requirements or PA has been obtained through eviCore healthcare) to the rendering provider at the time of the request for advanced imaging services.

### Exemption from Prior Authorization Requirements Not Available for Positron Emission Tomography

Decision support for PET (positron emission tomography) is not available in all advanced imaging decision support tools. Therefore, PET will not be eligible to be exempted from PA requirements at this time. ForwardHealth may review its policies and requirements in response to any future developments in decision support tools, including the addition of PET decision support tools to the PA exemption.

## Process for Obtaining an Exemption from Prior Authorization Requirements

Requesting providers with advanced imaging decision support tools may request exemption from PA requirements for CT, MR, and MRE imaging services using the following process:

1. Complete a Prior Authorization Requirements Exemption Request for CT, MR, and MRE Imaging Services (Prior Authorization Requirements Exemption Request for Computed Tomography (CT), Magnetic Resonance (MR), and Magnetic Resonance Elastography (MRE) Imaging Services, F-00787 (02/2019)) and agree to its terms.
2. Submit the completed Prior Authorization Requirements Exemption Request for CT, MR, and MRE Imaging Services to the mailing or email address listed on the form. Once received, ForwardHealth will review the exemption request materials, approve or deny the request, and send a decision letter to the requesting provider within 60 days after receipt of all necessary documentation. ForwardHealth will contact the requesting provider if any additional information is required for the application.
3. If the exemption request is approved, submit a list of all individual providers who order CT, MR, and MRE scans using the requesting provider's decision support tool. Exemptions are verified using the NPI (National Provider Identifier) of the individual ordering provider; therefore, requesting providers should submit a complete list of all individual ordering providers within the requesting provider's group to ForwardHealth. Lists may be submitted via email to DHSPAExemption@wisconsin.gov.

# Process for Maintaining an Exemption from Prior Authorization Requirements

To maintain exemption from PA requirements for advanced imaging services, the requesting provider is required to report the following outcome measures to ForwardHealth for the previous full six-month interval (January 1 through June 30 and July 1 through December 31) by July 31 and January 31 of each year:

- Aggregate score for all ordering providers that measures consistency with system recommendations based on the reporting standards described in more detail in Section III of the Prior Authorization Requirements Exemption Request for CT, MR, and MRE Imaging Services form
- Subset scores, grouped by primary and specialty care
- Aggregate outcome measures identified in the quality improvement plan

ForwardHealth will work with requesting providers to determine the most appropriate quality metrics. All requesting providers will need to provide similar data based on their reporting capabilities. This information should be submitted by the July 31 and January 31 deadlines to DHSPAExemption@wisconsin.gov.

Refer to the Prior Authorization Requirements Exemption Request for CT, MR, and MRE Imaging Services form for more detailed information on quality improvement plans and maintaining exemption from PA requirements. Providers with questions regarding the requirements may email them to DHSPAExemption@wisconsin.gov. If a requesting provider's quality improvement plan changes over time, any additional information identified in the plan must also be reported to this email address.

ForwardHealth may discontinue an exemption after initial approval if it determines the requesting provider either no longer meets the requirements outlined previously or does not demonstrate meaningful use of decision support to minimize inappropriate utilization of CT, MR, and MRE imaging services.

## Updating the List of Eligible Providers

The requesting provider is required to maintain the list of individual ordering providers eligible for the exemption. The requesting provider will have two mechanisms for updating the list of individual ordering providers eligible for the exemption: individual entry of provider NPIs or uploading a larger, preformatted text file.

The requesting provider may enter individual NPIs using the Prior Authorization Exempted link under the Quick Links box in the secure Provider area of Portal.

For larger lists of providers eligible for exemption, requesting providers should upload a text file to the Portal that includes the individual provider NPIs, start dates for exemption, and end dates for exemption, if applicable. All submitted NPIs will be matched to the ForwardHealth provider file. ForwardHealth will notify the requesting provider monthly, using the email contact indicated on the exemption application form, of any NPIs that cannot be matched.

ForwardHealth will enable the requesting provider's Portal administrator and delegated clerks to update the individual ordering providers for whom the exemption applies by July 1, 2013. Any changes that need to be made prior to that time for individual ordering providers eligible for the exemption should be sent to DHSPAExemption@wisconsin.gov.

The individual providers listed may order CT, MR, and MRE imaging services without requesting PA for any DOS on and after the date the requesting provider indicates those providers are eligible to use the decision support tool, regardless of the date an individual provider's information was submitted to ForwardHealth.

For example, ABC Health Clinic is approved for an exemption from PA requirements on June 1. Dr. Smith of ABC Health Clinic orders an MR imaging service on June 15. It is discovered on June 20 that Dr. Smith was mistakenly excluded from ABC Health Clinic's exemption list. Once Dr. Smith is added to the exemption list, she is covered under the exemption going back to the date

ABC Health Clinic indicated she was eligible to use the clinic's decision support tool.

## Providers Rendering Advanced Imaging Services

Providers rendering advanced imaging services are encouraged to verify that either a PA request has been approved for the member (verified by contacting eviCore healthcare or the ordering provider), or the ordering provider is exempt from PA (verified by contacting the ordering provider) prior to rendering the service.

### Claim Submission

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

Providers are also reminded to include the NPI of the ordering provider on the claim if the ordering provider is different from the rendering provider. If a PA request was not approved for the member and an exempt ordering provider's NPI is not included on the claim, the claim will be denied.

Topic #10678

# Prior Authorization for Advanced Imaging Services

Most advanced imaging services, including CT (computed tomography), MR (magnetic resonance), MRE (magnetic resonance elastography), and PET (positron emission tomography) imaging, require PA (prior authorization) when performed in either outpatient hospital settings or in non-hospital settings (e.g., radiology clinics). eviCore healthcare, a private radiology benefits manager, is authorized to administer PA for advanced imaging services on behalf of ForwardHealth. Refer to the Prior Authorization section of the Radiology area of the Online Handbook for PA requirements and submission information for advanced imaging services.

Health systems, groups, and individual providers that order CT, MR, and MRE imaging services and have implemented decision support tools may request an exemption from PA requirements for these services. Upon approval, ForwardHealth will recognize the requesting provider's advanced imaging decision support tool (e.g., ACR Select, Medicalis) as an alternative to current PA requirements for CT, MR, and MRE imaging services.

# Claims

# 4

**Archive Date:04/01/2024**

# Claims:Submission

Topic #17797

## 1500 Health Insurance Claim Form Completion Instructions

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

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

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

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

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

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

> ForwardHealth
> Claims and Adjustments
> 313 Blettner Blvd
> Madison WI 53784

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Topic #10677

# Advanced Imaging Services

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

## Submitting Claims for Situations Exempt From the Prior Authorization Requirement

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

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

## Service Provided During an Inpatient Stay

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

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

## Service Provided for Observation Status

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

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

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

## Service Provided as Part of Emergency Room Visit

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

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

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

## Service Provided as Emergency Service

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

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

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

## Ordering Provider Is Exempt from Prior Authorization Requirement

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

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

Topic #542

# Attached Documentation

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

Topic #15258

# Billing Under the EAPG System

Under the EAPG (Enhanced Ambulatory Patient Groups) system, Wisconsin Medicaid reimburses hospital providers for outpatient hospital services based on the quantity and type of services they provide. The system ensures that both low- and high-cost services are reimbursed appropriately.

Outpatient hospital providers will receive accurate and appropriate reimbursement under EAPG when they do the following:

- Bill usual and customary charges. The base reimbursement (reimbursement prior to an access payment being applied) under the EAPG system is limited to the total charge indicated on claims. Lab fees will be reimbursed at the lower of the total charge or the maximum allowable fee.
- Include all appropriate details on claims, as all details may be considered for reimbursement by the EAPG system. Omission of details may affect reimbursement.
- Indicate the appropriate HCPCS (Healthcare Common Procedure Coding System) or CPT (Current Procedural Terminology) procedure codes, as the EAPG system considers procedure codes without regard to revenue codes, except in the case of revenue codes indicating a continuous visit. ForwardHealth will continue to accept exempt revenue codes with no associated procedure code. However, these codes will result in a 999 EAPG (Unassigned) and the associated details will pay $0. All non-exempt revenue codes are required to have an appropriate procedure code.
- Use modifiers, as appropriate. The following are examples of modifiers that may be appropriate:
    - 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service).
    - 27 (Multiple outpatient hospital E/M encounters on the same date).
    - 59 (Distinct procedural service).
    - 76 (Repeat procedure or service by same physician or other qualified health care professional).
    - 77 (Repeat procedure by another physician or other qualified health care professional).
    - RT (Right side).
    - LT (Left side).
    - U1 (Non-emergent emergency room visit, eligible for $8 copay in accordance with 2017 Wisconsin Act 370). This modifier only applies to BadgerCare Plus and Wisconsin Medicaid.
- Enter a single DOS (date of service) per detail line; ForwardHealth recommends avoiding range dates at the detail level on claims. This may involve splitting a single detail with range dates into separate, unique details. The EAPG software recognizes only the first, or "from," DOS at the detail level. The claim may be priced inappropriately and reimbursement may be less than expected if range dates are used.
- Bill multiple visits using the following guidelines:
    - For multiple medical visits with different DOS, providers may bill more than one visit on a claim. The EAPG software treats details with different DOS as separate visits unless certain revenue codes (e.g. 045X, 0762) are used.
    - For multiple unrelated medical visits with the same DOS, ForwardHealth recommends providers bill the visits on separate claims and use condition code "G0" on the second claim submitted. The EAPG software is able to identify separate visits on the same DOS only when they are submitted on separate claims.

Topic #14958

# Billing for End-Stage Renal Disease Services

With the exception of a limited number of emergency dialysis treatments, when providing renal disease-related services within a hospital (e.g., internal dialysis unit) to a member diagnosed with ESRD (end-stage renal disease), providers must submit their claim using the NPI (National Provider Identifier), ZIP+4 code, and taxonomy code linked to their ESRD enrollment. Providers are reminded to submit the claim to the appropriate payer (i.e., Medicaid or WCDP (Wisconsin Chronic Disease Program)) based on the member's enrollment.

When providing up to three emergency dialysis treatments for a member, per calendar year, hospital providers may submit their claim using their NPI, ZIP+4 code, and taxonomy code linked to their hospital enrollment.

Reimbursement information is available.

Topic #19677

# Bone-Anchored Hearing Devices and Cochlear Implants

Wisconsin Medicaid separately reimburses DME (durable medical equipment) providers for bone-anchored hearing devices and cochlear implants when the implant surgery is performed in an ASC (ambulatory surgery center) or outpatient hospital and the rendering surgeon has submitted a claim for the surgery. The POS (place of service) codes for these facilities are as follows:

- "11" (Office)
- "19" (Off Campus — Outpatient Hospital)
- "22" (On Campus — Outpatient Hospital)
- "24" (Ambulatory Surgical Center)

Claims for bone-anchored hearing devices and bone-anchored hearing device surgery and cochlear implants and cochlear implant surgery are required to be submitted in a professional claim format (e.g., electronically using and 837 transaction, Direct Data Entry on the Portal, or Provider Electronic Solutions claims submission software, or on paper using the 1500 Health Insurance Claim Form).

The rendering surgeon is required to submit the claim for the surgery; the DME provider is required to submit the claim for the device.

*Note:* ForwardHealth will confirm that a claim for the bone-anchored hearing device surgery or cochlear implant surgery has been submitted prior to processing the DME provider's claim for the device. The DME provider is required to coordinate with the surgeon to ensure that the surgical claim is submitted first.

Topic #17017

# Claim Submission for Genetic Counseling

Genetic counselors cannot currently enroll independently with Wisconsin Medicaid and, therefore, cannot submit separate professional claims or be reimbursed for services provided in non-institutional settings. When genetic counseling services are provided by a trained genetic counselor, revenue code 510 (Clinic, General) and CPT (Current Procedural Terminology) procedure code 96040 (Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family) should be reported on the institutional claim form. Claim submission instructions for inpatient hospital services and outpatient hospital services are available.

Topic #21477

# Claims Submission for Emergency Department Copay

Hospitals should make a reasonable attempt to collect the $8 copay and submit the claim reflecting a non-emergent visit subject to the copay if all of the following conditions are met:

- The $8 copay applies to the member.
- The member did not meet the prudent layperson standard of a medical emergency.
- The member sought and received additional post-stabilization care in the emergency department after being informed of the $8 copay and availability of alternative providers with lesser or no cost share.

The institutional claim (UB-04) should include the U1 modifier on one of the codes in the 99281–99285 procedure code range for revenue code range 450–459 when the:

- Provider determines the member has a non-emergent condition, per 42 C.F.R. § 438.114. (The prudent layperson standard may be expanded to include a psychiatric emergency involving a significant risk or serious harm to oneself or others, a substance abuse emergency in which there is significant risk of serious harm to a member or others or there is likelihood of return to substance abuse without immediate treatment, or emergency dental care, which is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever or trauma.)
- Provider completes the steps in the Copay for Receiving Nonemergency Services in the Emergency Department section
- Member receives the non-emergent services in the emergency department

This billing requirement applies to all members who have qualified for BadgerCare Plus as an "adult without dependent children," including fee-for-service and HMO payers.

If the member is eligible for copay and is not exempt from the copay, the copay will be applied based on claims with a detail which must include the following combination:

- Modifier U1 (Non-emergent emergency room visit, eligible for $8 copay in accordance with 2017 Wisconsin Act 370)
- Procedure codes 99281–99285
- Revenue codes 450–459

Note: Professional claims submitted by the emergency department physicians are not subject to the non-emergent copay.

Topic #20082

# Claims for Drugs Purchased Through the 340B Drug Pricing Program

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

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

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

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

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

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

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

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

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

### Basis of Cost Determination and Submission Clarification Code

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

## Professional Claim Modifier for Drugs Purchased Through the 340B Program

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

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

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

Topic #6957

# Copy Claims on the ForwardHealth Portal

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

Topic #5017

# Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

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

Topic #1371

# Dates of Service and Multiple Visits

Providers have the option of submitting either one claim per DOS (date of service) or submitting one claim for a series of outpatient services. Submit all outpatient claims with a bill type of "131," with the exception of Medicare crossovers, where the appropriate Medicare bill type is accepted.

When billing multiple visits, providers should note the following guidelines:

- For multiple medical visits with different DOS, providers may bill more than one visit on a claim. Details with different DOS are treated as separate visits unless certain revenue codes (e.g. 045X, 0762) are used.
- For multiple unrelated medical visits with the same DOS, ForwardHealth recommends providers bill the visits on separate

claims and indicate condition code "G0" (Distinct medical visit) on the second claim submitted. Separate visits on the same DOS can be identified only when the visits are submitted on separate claims.

A single outpatient claim must not contain DOS spanning more than one calendar month. The revenue description and code are required to be on the same line, with the respective individual DOS on subsequent lines.

Topic #1353

# Dilation and Curettage

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

Topic #4997

# Direct Data Entry of Professional and Institutional Claims on the Portal

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

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

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

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

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

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

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

- Type of bill
- Patient status
- Visit point of origin
- Visit priority
- Diagnosis codes
- Revenue codes
- Procedure codes
- HIPPS (Health Insurance Prospective Payment System) codes

- Modifiers

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

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

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

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

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

Topic #15957

# Documenting and Billing the Appropriate National Drug Code

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

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

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

Topic #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 #1370

## Electronic Claim Submission for Outpatient Hospital Services

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

Electronic claims for outpatient hospital PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services must be submitted using the 837P (837 Health Care Claim: Professional) transaction.

Electronic claims for outpatient hospital PT, OT, and SLP evaluations and re-evaluations provided during an outpatient hospital specialty clinic visit must be submitted using the 837I transaction.

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

## Provider Electronic Solutions Software

DMS (Division of Medicaid Services) offers electronic billing software at no cost to providers. 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 #4511

# Entering Amounts for Covered and Noncovered Days

When entering covered or noncovered days on the UB-04 Claim Form, providers are required to indicate the number of days using two decimal places. For example, to indicate one day, providers would enter "1.00" in the value codes amount field of Form Locators 39-41 a-d; to indicate 12 days, providers would enter "12.00." Providers are required to indicate a value of "1.00" in the value code amounts field when admittance and discharge occur on the same day.

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 #15137

# Institutional Claims for OnabotulinumtoxinA (Botox) to Treat Urinary Incontinence

Claims for Botox to treat urinary incontinence in an outpatient hospital setting must be submitted on an institutional claim using one of the following:

- The 837I (837 Health Care Claim: Institutional) transaction
- PES (Provider Electronic Solutions) software
- DDE (Direct Data Entry) on the ForwardHealth Portal
- A UB-04 Claim Form

*Note:* Claims for Botox to treat urinary incontinence anywhere other than in an outpatient hospital setting should be submitted according to the claims submission requirements for physician-administered drugs.

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 #18017

# Observation

## Indicating Dates of Service

For institutional claims for both outpatient and inpatient hospital services, the "from" DOS (date of service) is the date on which the member first received care. If observation was the first service provided, then the date observation began must be indicated as the "from" DOS. Additionally, the "to" DOS is the last date on which the member received care. This may be the date that the member was released without being admitted to the hospital or the date that the member, who was admitted as an inpatient, was discharged from the hospital.

# Indicating Observation Information

For institutional claims for both outpatient and inpatient hospital services, the following must be indicated on the claim detail specifying observation:

- Revenue code 0762 (Specialty services — Observation hours)
- Number of hours that the member was under observation as the number of units

Note: Revenue code 0762 is exempt from the requirement to indicate a corresponding HCPCS (Healthcare Common Procedure Coding System) or CPT (Current Procedural Terminology) procedure code on the claim detail; however, providers submitting institutional claims for outpatient hospital services are encouraged to indicate the corresponding HCPCS or CPT procedure code in order to be reimbursed appropriately under the EAPG (Enhanced Ambulatory Patient Groups) system. Claim details that indicate revenue code 0762 without a corresponding HCPCS or CPT procedure code will receive a 999 (Unassigned) EAPG and will be reimbursed $0.

Claims indicating observation hours above what ForwardHealth allows under the observation policy will be denied. If the member is kept in observation for more hours than ForwardHealth allows and is subsequently admitted as an inpatient or dismissed, the number of hours billed with revenue code 0762 should be prorated, and the provider should indicate a non-covered span for the remaining observation period. Providers can use occurrence span code 74 to indicate a non-covered level of care on the UB-04 claim form. The "from" and "to" DOS, indicated in Form Locator 6 (Statement Covers Period), should reflect the entire period in which care was provided, in keeping with the ForwardHealth continuous stay policy, but services rendered during the non-covered span should not be billed on the claim.

## Examples of Indicating Observation Information

Example 1: The member presents at 1:00 AM on January 5 and is placed in observation for 24 hours, then admitted for a three-day inpatient stay.

- Statement covers period: January 5 through January 9
- Admission date: January 6
- Bill 24 units with revenue code 0762
- Entire span is covered

Example 2: The member presents at 1:00 AM on January 5 and is placed in observation for 60 hours, then admitted for a three-day inpatient stay. Requirements for allowing greater than 48 hours of observation are not satisfied.

- Statement covers period: January 5 through January 10
- Admission date: January 7
- Bill 48 units with revenue code 0762
- Indicate a non-covered span starting and ending on January 7

Example 3: The member presents at 1:00 AM on January 5 and is placed in observation for 84 hours, then admitted for a three-day inpatient stay. Requirements for allowing greater than 48 hours of observation are not satisfied.

- Statement covers period: January 5 through January 11
- Admission date: January 8
- Bill 48 units with revenue code 0762
- Indicate a non-covered span starting on January 7 and ending January 8

Example 4: The member presents at 1:00 AM on January 5 and is placed in observation for 84 hours, then dismissed. Requirements for allowing greater than 48 hours of observation are not satisfied.

- Statement covers period: January 5 through January 8
- Admission date: not applicable
- Bill 48 units with revenue code 0762
- Indicate a non-covered span starting on January 7 and ending January 8

Example 5: The member presents at 1:00 AM on January 5 and is placed in observation for 72 hours, then dismissed. Requirements for allowing greater than 48 hours of observation **are** satisfied.

- Statement covers period: January 5 through January 8
- Admission date: not applicable
- Bill 72 units with revenue code 0762
- Do not indicate a non-covered span

Topic #561

# Paper Claim Form Preparation and Data Alignment Requirements

## Optical Character Recognition

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

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

## Speed and Accuracy of Claims Processing

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

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

### Handwritten Claims

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

### Use Original Claim Forms

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

## Use Laser or Ink Jet Printers

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

## Alignment

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

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

The following sample claim forms demonstrate correct and incorrect alignment:

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

## Clarity

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

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

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

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

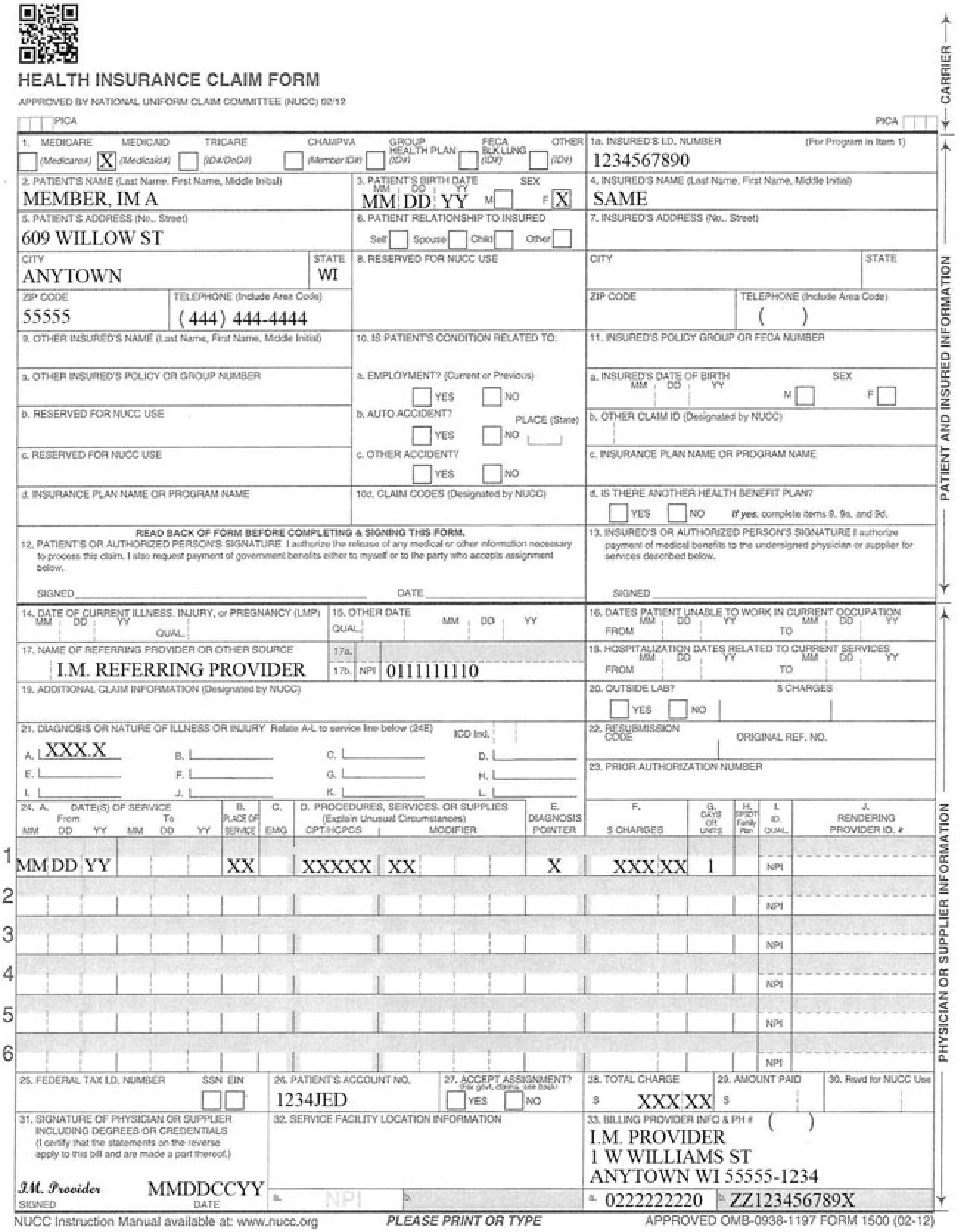
## Staples, Correction Liquid, and Correction Tape

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

## Additional Diagnosis Codes

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

# Sample of a Correctly Aligned 1500 Health Insurance Claim Form



**HEALTH INSURANCE CLAIM FORM**

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

PICA ☐☐☐ PICA ☐☐☐

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

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

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

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

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: I.M. REFERRING PROVIDER 17a. 17b. NPI 0111111110

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

A. XXX.X B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

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

26. PATIENT'S ACCOUNT NO.: 1234JED

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

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

*I.M. Provider* MMDDCCYY
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )
I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234

a. 0222222220 b. ZZ123456789X

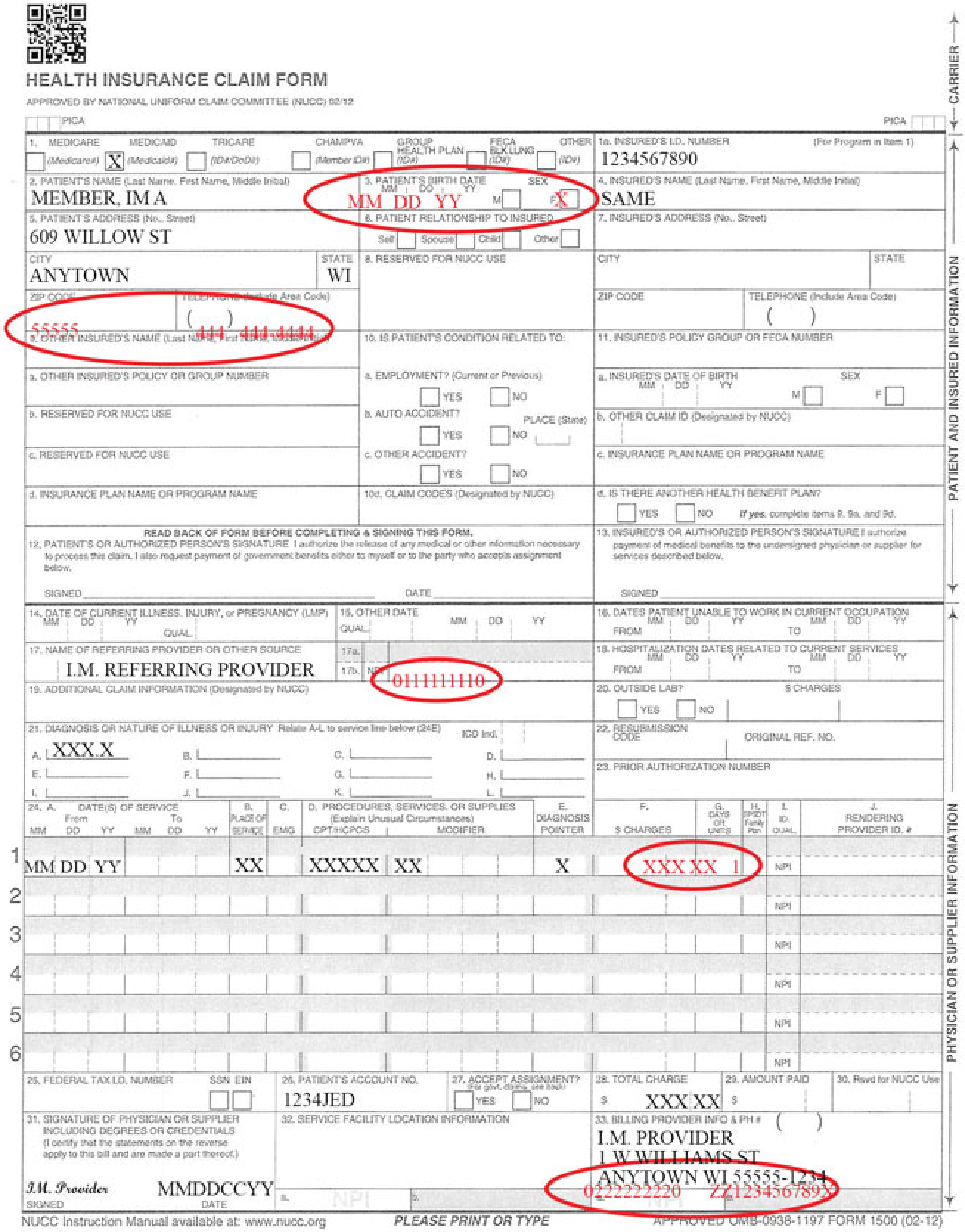
NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

# Sample of an Incorrectly Aligned 1500 Health Insurance Claim Form



## HEALTH INSURANCE CLAIM FORM

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

☐☐☐ PICA — PICA ☐☐☐

CARRIER

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

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

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐
MM DD YY 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 TELEPHONE (Include Area Code) ( )
55555 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 ______

PATIENT AND INSURED INFORMATION

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 FROM MM DD YY TO MM DD YY

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

17a.

17b. NPI
0111111110

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

PHYSICIAN OR SUPPLIER INFORMATION

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

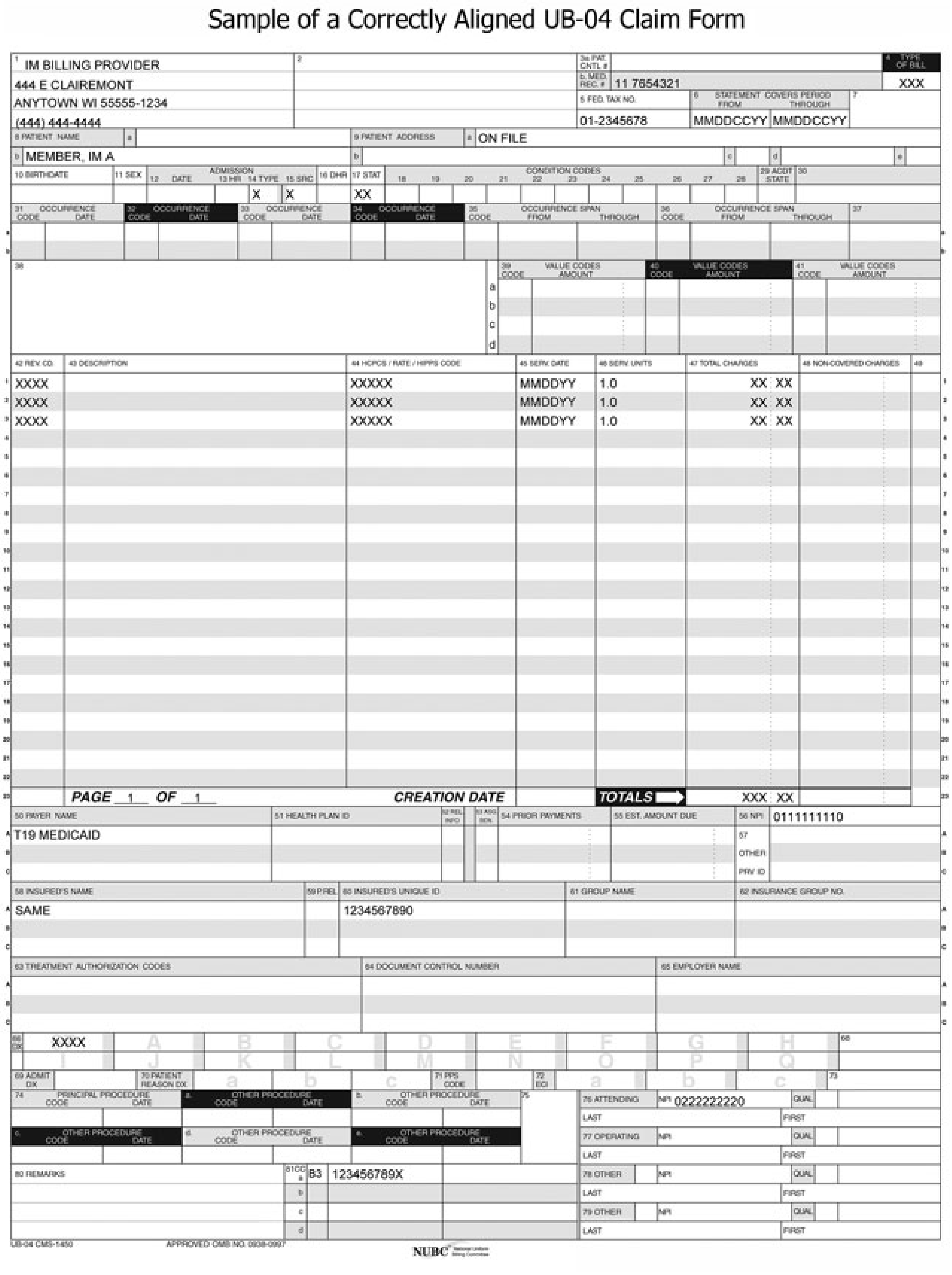
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
I.M. Provider MMDDCCYY
SIGNED DATE

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. NPI 0222222220 b. ZZ123456789X

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-1197 FORM 1500 (02-12)

# Sample of 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 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

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

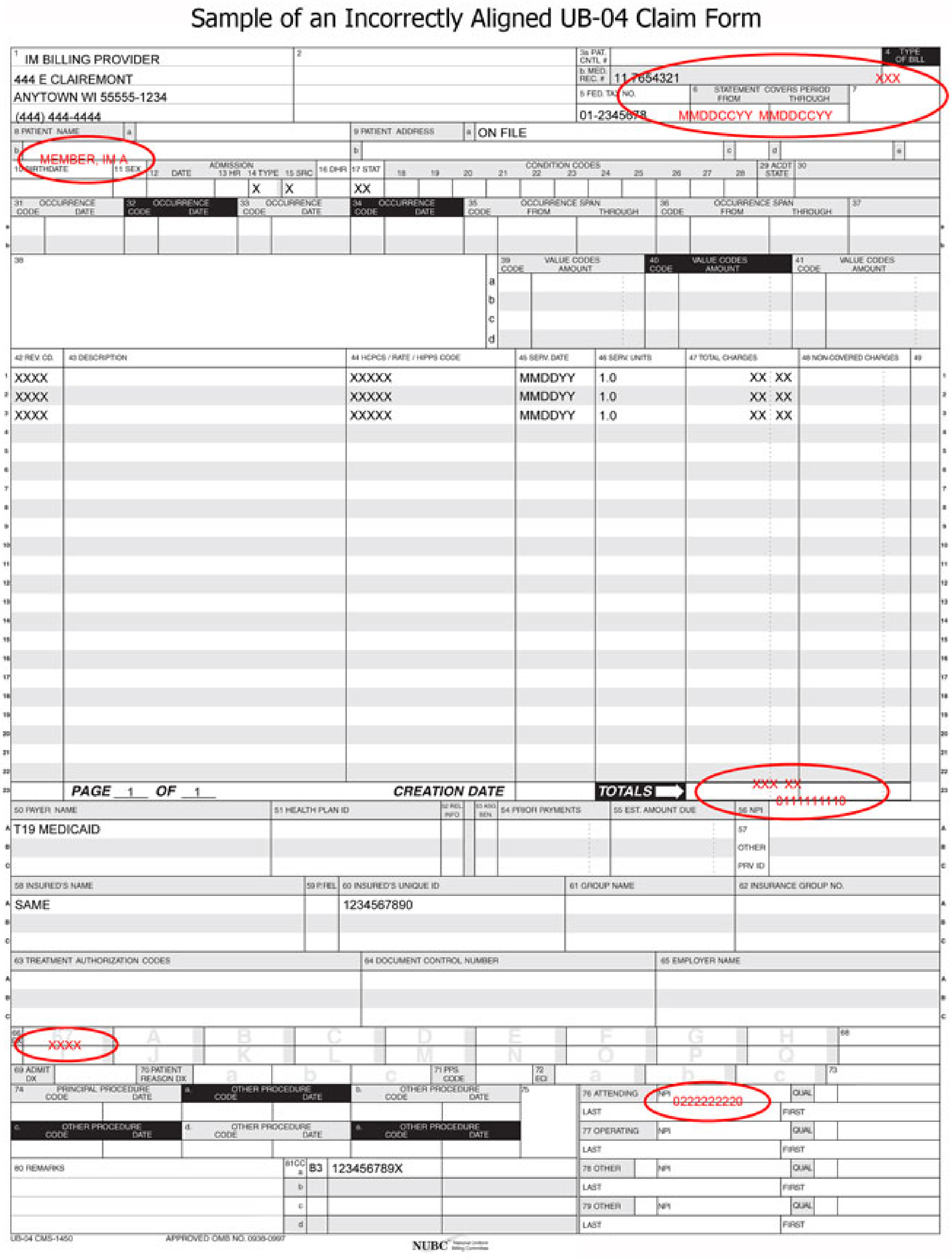
69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c
73

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

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

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

b. MED. REC. # 11 7654321

4 TYPE OF BILL XXX

5 FED. TAX NO. 01-2345678

6 STATEMENT COVERS PERIOD FROM THROUGH MMDDCCYY MMDDCCYY

8 PATIENT NAME b MEMBER, IM A

9 PATIENT ADDRESS a ON FILE

14 TYPE X

15 SRC X

17 STAT XX

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 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

56 NPI 0111111110

50 PAYER NAME A T19 MEDICAID

58 INSURED'S NAME A SAME

60 INSURED'S UNIQUE ID 1234567890

66 DX XXXX

76 ATTENDING NPI 0222222220

81CC a B3 123456789X

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

Topic #1369

# Paper Claim Submission

Paper claims for outpatient hospital services must be submitted using the UB-04 Claim Form. Claims are denied for outpatient hospital services submitted on any other claim form. Providers should use the appropriate claim form instructions for outpatient hospital services when submitting these claims.

Paper claims for outpatient hospital PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services must be submitted using the 1500 Health Insurance Claim Form ((02/12)). Providers are to use the appropriate claim form instructions when submitting these claims.

Paper claims for outpatient hospital PT, OT, and SLP evaluations and re-evaluations provided during an outpatient hospital specialty clinic visit must be submitted using the UB-04 Claim Form.

## Obtaining the Claim Forms

ForwardHealth does not provide national claim forms. The forms may be obtained from any federal forms supplier.

Topic #22797

# Payment Integrity Review Supporting Documentation

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

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

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

Topic #13337

# Professional Services

When provided in an inpatient hospital setting, professional and other services must be submitted on a professional claim by a separately certified provider when the following professionals are providing them or the services themselves are:

- Air, water, and land hospital-based ambulance
- Anesthesia assistants
- Audiologists
- CRNAs (Certified registered nurse anesthetists)
- Chiropractors
- Dentists
- DME (Durable medical equipment) and supplies for non-hospital use
- Hearing aid dealers
- Independent nurse practitioners
- Nurse midwives
- Optometrists
- Pharmacy, for take home drugs on the date of discharge
- Physician assistants
- Physicians
- Podiatrists
- Psychiatrists
- Psychologists
- SMV (Specialized medical vehicle) transportation

These services are ineligible for reimbursement under the DRG (Diagnosis Related Group) payment system for inpatient hospital services.

When provided in an outpatient hospital setting, the following professional and other services must be submitted on a professional claim by a separately certified provider:

- DME
- Provider-based ESRD (end-stage renal disease) services
- Therapy services (with certain exceptions)

These services are ineligible for reimbursement under the EAPG (Enhanced Ambulatory Patient Group) payment system for outpatient hospital services.

Topic #23039

# Qualifying Clinical Trials

ForwardHealth requires the following on all claims submitted for routine services associated with participation in a clinical trial:

- The National Clinical Trial number
- HCPCS (Healthcare Common Procedure Coding System) modifier Q1
- An ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) diagnosis code to indicate the services are associated with a clinical trial, such as Z00.6

Topic #10637

# Reimbursement Reduction for Most Paper Claims

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

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

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

The reimbursement reduction applies to the following paper claims:

- 1500 Health Insurance Claim Form ((02/12))
- UB-04 (CMS 1450) Claim Form
- Compound Drug Claim (F-13073 (04/2017)) form
- Noncompound Drug Claim (F-13072 (04/2017)) form

## Exceptions to Paper Claim Reimbursement Reduction

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

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

Topic #21197

# Select High Cost, Orphan, and Accelerated Approval Drugs

For the interim, select high cost, orphan, and accelerated approval drugs will be covered and reimbursed under the pharmacy benefit. When a noncompound drug is covered under the pharmacy benefit, providers may submit claims for the cost of the drug to ForwardHealth through one of the following methods:

- Real-time POS (point-of-sale) system using the NCPDP (National Council for Prescription Drug Programs) Telecommunication Standard
- ForwardHealth Portal
- PES (Provider Electronic Solutions) software
- Noncompound Drug Claim (F-13072 (04/2017)) form

Related physician and clinical services associated with the administration of the drug will be reimbursed separately based on existing coverage and reimbursement policy.

The Services Requiring Prior Authorization chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook contains clinical criteria for select high cost, orphan, and accelerated approval drugs that are identified in the Select

High Cost, Orphan, and Accelerated Approval Drugs data table.

## Pharmacy Direct Billing for Select High Cost, Orphan, and Accelerated Approval Drugs

To clarify, if a provider or facility obtains a drug that is specifically addressed in the Select High Cost, Orphan, and Accelerated Approval Drugs data table from a pharmacy provider, then the administering provider or facility may not bill for the cost of that drug because the pharmacy provider will bill for the cost of the drug.

It is the responsibility of the pharmacy provider to use appropriate management and packaging practices to ensure drug stability and integrity are maintained during drug shipment and delivery. Once the drug is in possession of the administering provider or facility, it is the responsibility of the administering provider or facility to use appropriate management and storage practices to ensure drug stability and integrity are maintained. If a drug is damaged prior to administration or is delivered but not administered to a member, ForwardHealth will not reimburse for the cost of the drug; it is the responsibility of the administering provider or facility to alert the pharmacy provider and the responsibility of the pharmacy provider to reverse their claim to ForwardHealth and work with the pharmaceutical company or administering provider or facility regarding payment for the damaged or wasted drug.

For the interim, select high cost, orphan, and accelerated approval drugs will be covered under the pharmacy benefit, but it is the responsibility of the health care provider to determine the medically appropriate setting for administration. Providers are required to comply with all relevant safety protocols when administering these drugs to ForwardHealth members.

For specific questions about institutional billing or coverage of high cost, orphan, and accelerated approval drugs listed in the Select High Cost, Orphan, and Accelerated Approval Drugs data table, providers may contact Provider Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

Note: Select high cost, orphan, and accelerated approval drugs covered under the pharmacy benefit will not be covered as physician-administered drugs. When a high cost, orphan, or accelerated approval drug is covered under the pharmacy benefit, it will be reimbursed fee-for-service and MCOs (managed care organizations) will not be responsible for the cost of the drug, but MCOs are still responsible for the physician and clinical services associated with the high cost, orphan, or accelerated approval drug.

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.

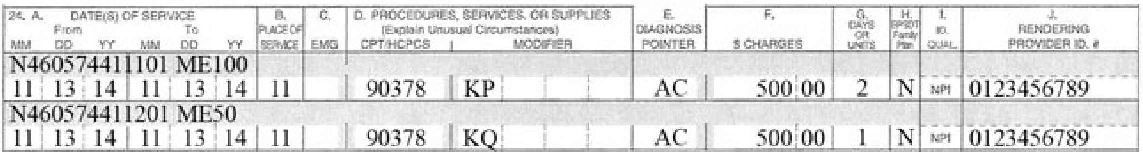
## Claim Submission Instructions for Claims With Two or Three National Drug Codes

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**



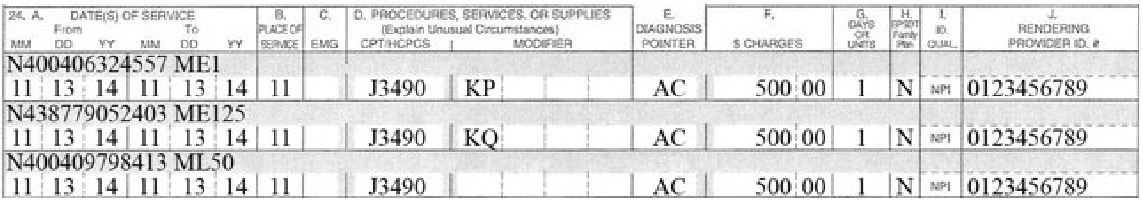
| | 24. A. DATE(S) OF SERVICE From MM | From DD | From YY | To MM | To DD | To YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. |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

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

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

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

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

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

Topic #1352

# Submitting Newborn Claims

When a woman gives birth, the hospital provider is required to submit separate claims for the hospital stay of the woman and the hospital stay of her newborn. In addition, the newborn's birth weight must only be recorded on the newborn's claim, using Value Code 54.

Hospital claims for births may be submitted using any of the following submission methods:

- Provider Electronic Solutions
- Direct Data Entry on the ForwardHealth Portal
- UB-04 claim form
- 837 Health Care Claim: Institutional (837I) (p00266) transaction

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 (03/2023)). 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 seven calendar days to find a match. If a match cannot be made within seven 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 #3304

# Therapy Services

Providers should refer to the Therapies service area for 1500 Health Insurance Claim Form ((02/12)) instructions when submitting claims for outpatient PT (physical therapy), OT (occupational therapy), or SLP (speech and language pathology) services.

Topic #4453

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

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

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

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

*Note:* Every code used on this claim form, even if the code is entered in a non-required form locator, is required to be a valid code. Each provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of claims relating to reimbursement for services submitted to ForwardHealth.

When submitting paper claims, if the member has any other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) 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

**Form Locator 1 — Provider Name, Address, and Telephone Number**
Enter the name of the hospital submitting the claim and the hospital's complete practice location address. The minimum requirement is the hospital's name, city, state, and ZIP+4 code. Do not enter a Post Office Box or a ZIP+4 code associated with a PO Box. The name in Form Locator 1 should correspond with the NPI (National Provider Identifier) in Form Locator 56.

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

**Form Locator 3a — Pat. Cntl # (optional)**
Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the RA (Remittance Advice) and/or the 835 (835 Health Care Claim Payment/Advice) transaction.

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

835 transaction.

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

- 131 = Hospital, outpatient, admit through discharge claim
- 851 = Special facility, critical access hospital, admit through discharge claim

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

**Form Locator 6 — Statement Covers Period (From - Through)**
Enter the from and through dates on which services were rendered in MMDDYY format (for example, November 3, 2008, would be 110308).

**Form Locator 7 — Unlabeled Field (not required)**

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

**Form Locator 9 a-e — Patient Address**
Data are required in this form locator for OCR processing. Any information populated by a provider's computer software is acceptable data for this form locator (for example, "On file"). If computer software does not automatically complete this form locator, enter information such as the member's complete address in field 9a.

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

**Form Locator 11 — Sex (not required)**

**Form Locator 12 — Admission/Start of Care Date (not required)**

**Form Locator 13 — Admission Hr (not required)**

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

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

**Form Locator 16 — DHR (not required)**

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

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

information.

**Form Locator 29 — ACDT State (not required)**

**Form Locator 30 — Unlabeled Field (not required)**

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

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

**Form Locator 37 — Unlabeled Field (not required)**

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

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

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

**Form Locator 43 — Description (not required)**

**Form Locator 44 — HCPCS/Rate/HIPPS Code**
Enter the appropriate HCPCS (Healthcare Common Procedure Coding System) or CPT (Current Procedural Terminology) code that corresponds to the revenue code listed in Form Locator 42. Certain revenue codes do not require HCPCS or CPT procedure codes. Enter the appropriate modifier(s) following the procedure code.

**Form Locator 45 — Serv. Date**
Enter the single "from" DOS (date of service) in MMDDYY format in this form locator.

**Form Locator 46 — Serv. Units**
Enter the number of covered accommodation days or ancillary units of service for each line item.

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

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

**Form Locator 49 — Unlabeled Field**
Enter the "to" DOS in DD format only if the detail line includes a range of consecutive dates. The revenue code, procedure code and modifiers (if applicable), service units, and the charge must be identical for each date within the range.

***Detail Line 23***

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

CREATION DATE (not required)

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

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

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

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

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

**Form Locator 54 A-C — Prior Payments (not required)**
This information 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 listed in Form Locator 50 A-C as an attachment(s) to their completed claim.

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

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

**Form Locator 57 — Other Provider ID (not required)**

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

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

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

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

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

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

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

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

**Form Locator 66 — Dx (not required)**

**Form Locator 67 — Principal Diagnosis Code and Present on Admission Indicator**
Enter the valid, most specific ICD (International Classification of Diseases) code describing the principal diagnosis (for example, the condition established after study to be chiefly responsible for causing the admission or other health care episode). The principal diagnosis identifies the condition chiefly responsible for the patient's visit or treatment. Do not enter manifestation codes as the principal diagnosis; code the underlying disease first. The principal diagnosis may not include External Cause of Morbidity codes.

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

**Form Locator 68 — Unlabeled Field (not required)**

**Form Locator 69 — Admit Dx (not required)**

**Form Locator 70 — Patient Reason Dx (not required)**

**Form Locator 71 — PPS Code (not required)**

**Form Locator 72 — ECI (not required)**

**Form Locator 73 — Unlabeled Field (not required)**

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

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

**Form Locator 75 — Unlabeled Field (not required)**

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

**Form Locator 77 — Operating (not required)**

**Form Locators 78 and 79 — Other Provider Name and Identifiers (not required)**

**Form Locator 80 — Remarks (not required)**

### *Commercial Health Insurance Billing Information*

This information 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 listed in Form Locator 50 A-C as an attachment(s) to their completed claim.

**Form Locator 81 a-d — CC**
If the billing provider's NPI was indicated in Form Locator 56, enter the qualifier "B3" in the first field to the right of the form locator, followed by the appropriate 10-digit provider taxonomy code on file with ForwardHealth in the second field.

*Note:* Providers should use qualifier "PXC" when submitting an electronic claim using the 837I (837 Health Care Claim:

Institutional) transaction. For further instructions, refer to the companion guide for the 837I transaction.

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 seven 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 for seven days before denying for not receiving the attachment.

# Responsibilities

Topic #516

## Accuracy of Claims

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

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

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

Topic #366

## Copayment Amounts

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

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

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

Topic #22798

## Payment Integrity Review Program

The PIR (Payment Integrity Review) program:

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

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

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

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

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

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

## Payment Integrity Review Program Overview

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

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

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

## Types of Payment Integrity Review

There are three types of review in the PIR program:

- Claims Review
- Pre-Payment Review
- Intermediate Sanctions

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

| | Claims Review | Pre-Payment Review | Intermediate Sanction |
|---|---|---|---|
| **How claims are selected for review** | A sampling of claims is selected from providers, provider types, benefit areas, or service codes identified by the OIG. | The OIG has reasonable suspicion that a provider is violating program rules. | The OIG has established cause that a provider is violating program rules. |
| **How providers are notified that selected claims are under review** | The provider receives a message on the Portal. | The provider receives a Provider Notification letter and message on the Portal. | The provider receives a Notice of Intermediate Sanction letter and message on the Portal. |
| **How to successfully exit the review** | Claims are selected for review based on a pre-determined percentage of claim submissions of specific criteria. | 75 percent of a provider's reviewed claims over a three-month period must be paid as submitted. The number of | The provider must meet parameters set during the sanction process. |

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

## Claims Review

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

## Pre-Payment Review

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

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

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

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

## Intermediate Sanction Review

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

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

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 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.

## 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.

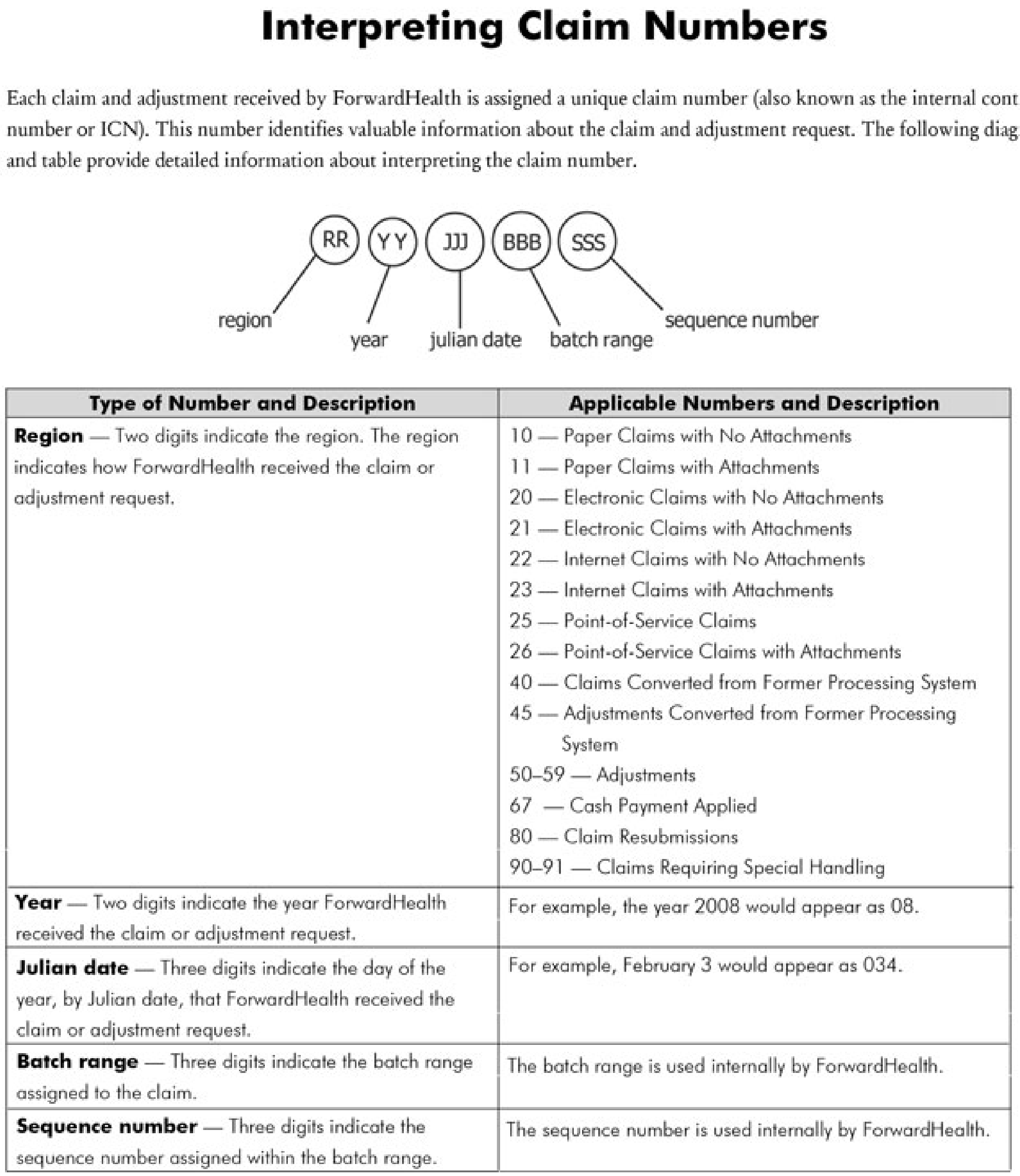
Topic #534

# 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.

RR
YY
JJJ
BBB
SSS
region
year
julian date
batch range
sequence 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<br>11 — Paper Claims with Attachments<br>20 — Electronic Claims with No Attachments<br>21 — Electronic Claims with Attachments<br>22 — Internet Claims with No Attachments<br>23 — Internet Claims with Attachments<br>25 — Point-of-Service Claims<br>26 — Point-of-Service Claims with Attachments<br>40 — Claims Converted from Former Processing System<br>45 — Adjustments Converted from Former Processing System<br>50–59 — Adjustments<br>67 — Cash Payment Applied<br>80 — Claim Resubmissions<br>90–91 — Claims Requiring Special Handling |
| **Year** — Two digits indicate the year ForwardHealth received the claim or adjustment request. | For example, the year 2008 would appear as 08. |
| **Julian date** — Three digits indicate the day of the year, by Julian date, that ForwardHealth received the claim or adjustment request. | For example, February 3 would appear as 034. |
| **Batch range** — Three digits indicate the batch range assigned to the claim. | The batch range is used internally by ForwardHealth. |
| **Sequence number** — Three digits indicate the sequence number assigned within the batch range. | The sequence number is used internally by ForwardHealth. |

Topic #535

# Claim Status

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

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

Topic #4746

# Cutback Fields on the Remittance Advice for Adjusted and Paid Claims

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

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

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

Topic #15278

# EAPGs in Remittance Advices

The EAPG (Enhanced Ambulatory Patient Groups) system assigns an EAPG to applicable details in order to categorize the services for payment; for a list of EAPGs, refer to the Hospital Rates and Weights page on the ForwardHealth Portal.

EAPGs appear on the 835 (835 Health Care Claim Payment/Advice) transaction and in the detail section of the TXT (text) format file of the RA (Remittance Advice).

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. 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. The 1995 Office Excel for Windows (Version 7.0) included in Office 95 or a newer version is recommended for maximum file capabilities when downloading the CSV file. 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 Change Healthcare ClaimsXten and in ForwardHealth interChange.

## Medically Unlikely Detail Edits

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

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

## Procedure-to-Procedure Detail Edits

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

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

## Quarterly Code List Updates

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

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

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

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

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

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

Topic #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 ((02/12)) |
| Noncompound and compound drug claims | Pharmacies and dispensing physicians |
| Outpatient claims | Outpatient hospital providers and hospice providers |
| Professional claims | Ambulance providers, ambulatory surgery centers, anesthesiologist assistants, audiologists, case management providers, certified registered nurse anesthetists, chiropractors, community care organizations, community support programs, crisis intervention providers, day treatment providers, family planning clinics, federally qualified health centers, HealthCheck providers, HealthCheck "Other Services" providers, hearing instrument specialists, home health agencies, independent labs, individual medical supply providers, medical equipment vendors, mental health/substance abuse clinics, nurses in |

| | |
|---|---|
| | independent practice, nurse practitioners, occupational therapists, opticians, optometrists, personal care agencies, physical therapists, physician assistants, physician clinics, physicians, podiatrists, portable X-ray providers, prenatal care coordination providers, psychologists, rehabilitation agencies, respiratory therapists, rural health clinics, school-based services providers, specialized medical vehicle providers, speech and hearing clinics, speech-language pathologists, therapy groups |

Topic #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 (that is, 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 decreasing claim adjustments 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. Providers will see net difference between the claim and the adjustment reflected on the RA.

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<br>1—OBRA Level 1 screening void request<br>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 (that is, 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 **difference**—or pays the **difference**—between the original claim amount and the claim adjustment amount. This difference will be reflected on the RA.

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.

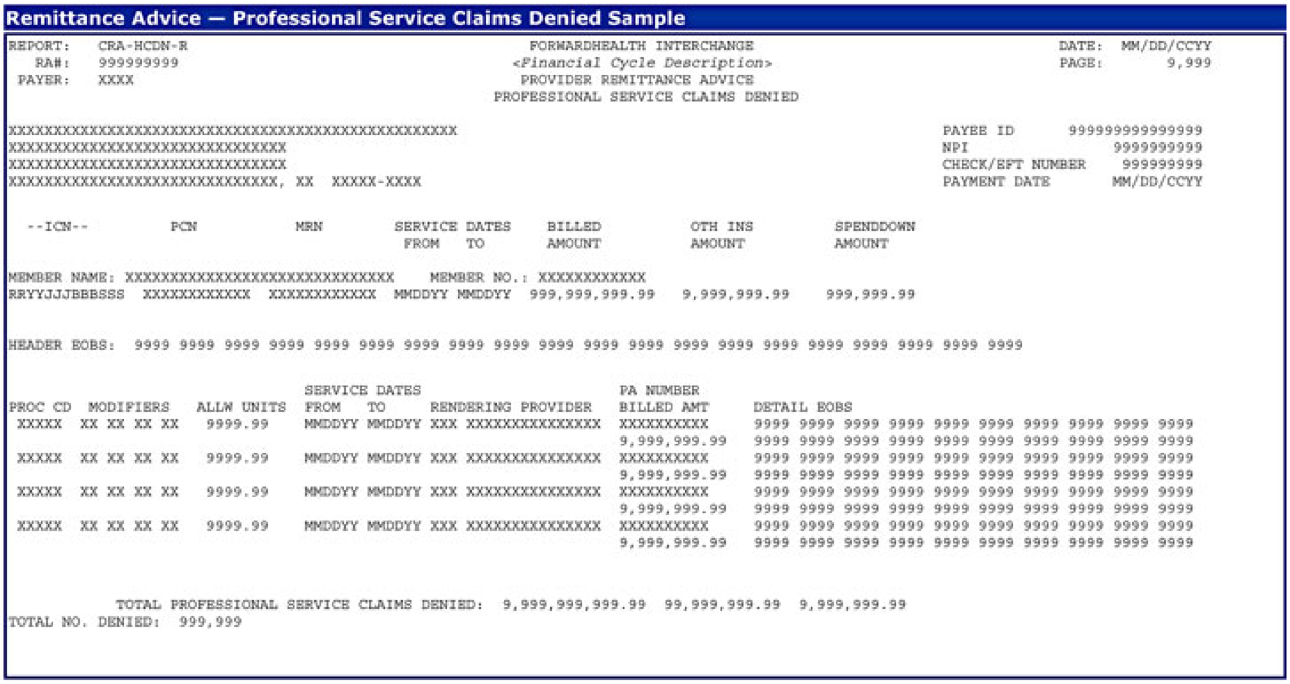
Topic #4824

# 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

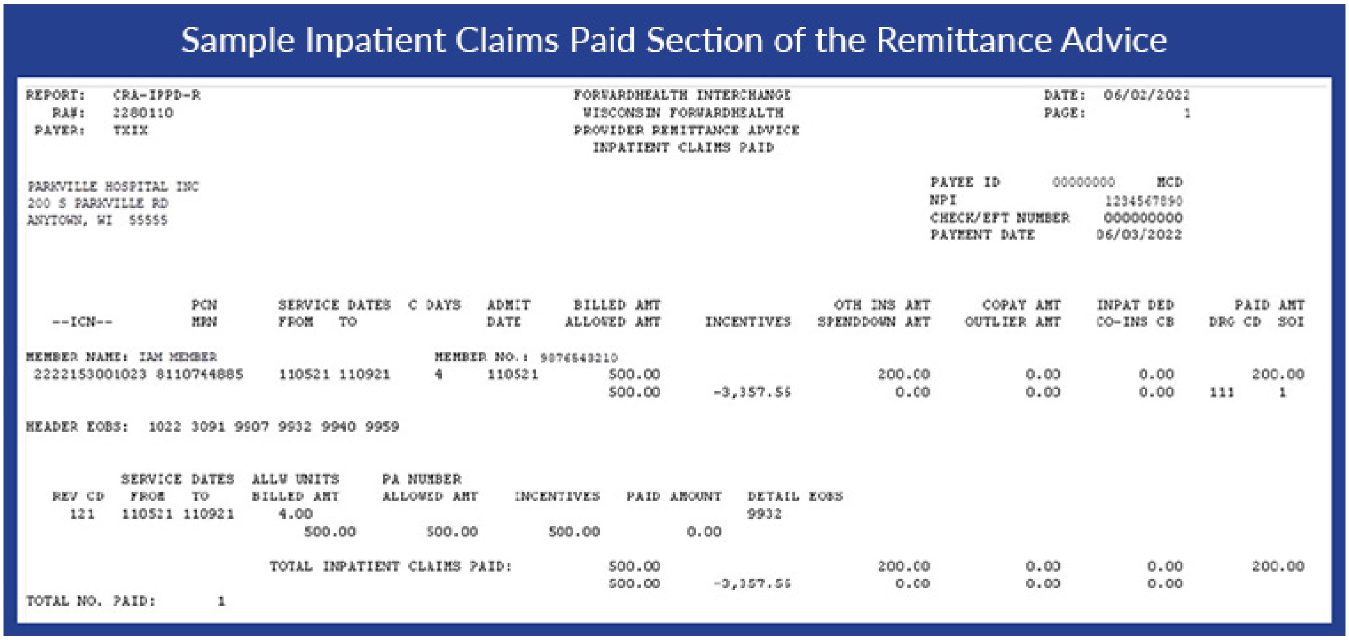
```
REPORT:   CRA-HCDN-R                              FORWARDHEALTH INTERCHANGE                                    DATE:  MM/DD/CCYY
  RA#:    999999999                             <Financial Cycle Description>                                  PAGE:       9,999
 PAYER:   XXXX                        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

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

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

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


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

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


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

Topic #4825

# Reading the Claims Paid Section of the Remittance Advice

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

In a paid claims section, providers will see the original claim information reported along with EOB (Explanation of Benefits) codes for both the header and the detail lines, if applicable. Providers should refer to the EOB Code Description section of the RA for more information about how the reimbursement amount was determined. The Incentives column is calculated in accordance with the 835 (835 Health Care Claim Payment/Advice) standards to balance between the service line, the claim, and the transaction.



Sample Inpatient Claims Paid Section of the Remittance Advice

```
REPORT:   CRA-IPPD-R                                              FORWARDHEALTH INTERCHANGE                                DATE:  06/02/2022
   RA#:   2280110                                                  WISCONSIN FORWARDHEALTH                                 PAGE:           1
 PAYER:   TXIX                                                    PROVIDER REMITTANCE ADVICE
                                                                    INPATIENT CLAIMS PAID

PARKVILLE HOSPITAL INC                                                                                          PAYEE ID       00000000     MCD
200 S PARKVILLE RD                                                                                              NPI                  1234567890
ANYTOWN, WI  55555                                                                                              CHECK/EFT NUMBER      000000000
                                                                                                                PAYMENT DATE         06/03/2022


                      PCN        SERVICE DATES  C DAYS   ADMIT     BILLED AMT                   OTH INS AMT     COPAY AMT     INPAT DED       PAID AMT
   --ICN--            MRN        FROM    TO              DATE     ALLOWED AMT     INCENTIVES  SPENDDOWN AMT   OUTLIER AMT    CO-INS CB     DRG CD  SOI

MEMBER NAME: IAM MEMBER                             MEMBER NO.: 9876543210
 2222153001023 8110744885    110521 110921      4      110521         500.00                         200.00          0.00          0.00         200.00
                                                                      500.00      -3,357.56            0.00          0.00          0.00     111       1

HEADER EOBS:   1022 3091 9907 9932 9940 9959


            SERVICE DATES  ALLW UNITS      PA NUMBER
   REV CD    FROM    TO    BILLED AMT      ALLOWED AMT     INCENTIVES    PAID AMOUNT    DETAIL EOBS
    121    110521 110921      4.00                                                        9932
                                 500.00           500.00         500.00          0.00

                                          TOTAL INPATIENT CLAIMS PAID:        500.00                         200.00          0.00          0.00         200.00
                                                                              500.00      -3,357.56            0.00          0.00          0.00
TOTAL NO. PAID:        1
```

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
- Claim sequence numbers

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
- Claim sequence numbers

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 (for example, 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 (for example, "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.

# 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 (08/2015)) 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.

# 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 (F-13047 (08/2015)) form with a paper claim or an Adjustment/Reconsideration Request (F-13046 (08/2015)) form 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 (08/2015)) 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 (08/2015)) 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 (08/2015)) 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:<br>• The correct liability amount or LOC must be indicated on the Adjustment/Reconsideration Request (F-13046 (08/15)) form.<br>• 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.<br>• A copy of the Explanation of Medical Benefits form, if applicable. | ForwardHealth<br>Timely Filing<br>Ste 50<br>313 Blettner Blvd<br>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:<br>• A complete copy of the decision notice received from the court, fair hearing, or DHS | ForwardHealth<br>Timely Filing<br>Ste 50<br>313 Blettner Blvd<br>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:<br>• A copy of remittance information showing the claim was submitted in a timely manner and denied with a qualifying enrollment-related explanation.<br>• A photocopy of **one** of the following indicating enrollment on | ForwardHealth<br>Good Faith/Timely Filing<br>Ste 50<br>313 Blettner Blvd<br>Madison WI |

| | | |
|---|---|---|
| | the DOS:<br>• Temporary Identification Card for Express Enrollment in BadgerCare Plus<br>• Temporary Identification Card for Express Enrollment in Family Planning Only Services<br>• The response received through Wisconsin's EVS (Enrollment Verification System) from a commercial eligibility vendor<br>• The transaction log number received through WiCall<br>• 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:<br>• A copy of the RA message that shows the ForwardHealth-initiated adjustment<br>• A copy of the Explanation of Medical Benefits form, if applicable | ForwardHealth<br>Timely Filing<br>Ste 50<br>313 Blettner Blvd<br>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:<br>• A copy of the Explanation of Medical Benefits form, if applicable<br>**And**<br>• "GR retroactive enrollment" indicated on the claim<br>**Or**<br>• A copy of the letter received from the income maintenance or tribal agency | ForwardHealth<br>GR Retro Eligibility<br>Ste 50<br>313 Blettner Blvd<br>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:<br>- The charges were previously submitted to Medicare.<br>- The member name and identification number do not match.<br>- The services were previously denied by Medicare.<br>- 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:<br>- A copy of the Medicare remittance information<br>- A copy of the Explanation of Medical Benefits form, if applicable | ForwardHealth<br>Timely Filing<br>Ste 50<br>313 Blettner Blvd<br>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:<br>- A copy of the recoupment notice<br>- An updated Explanation of Medical Benefits form, if applicable<br>*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<br>Timely Filing<br>Ste 50<br>313 Blettner Blvd<br>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<br>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<br>313 Blettner Blvd<br>Madison WI 53784 |

# Overpayments

Topic #532

# Adjustment Requests

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

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

- Medicaid-enrolled on the DOS (date of service).
- Not currently under investigation for Medicaid fraud or abuse.
- Not subject to any intermediate sanctions under 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 (08/2015)) 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 #531

# ForwardHealth-Initiated Adjustments

ForwardHealth may initiate an adjustment when a retroactive rate increase occurs or when an improper or excess payment has been made. ForwardHealth has the right to pursue overpayments resulting from computer or clerical errors that occurred during claims processing.

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

Topic #3449

# Requirements

As stated in 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 Wisconsin Medicaid or other health insurance sources.

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

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

- Return of overpayment through the adjustment request process
- ForwardHealth-initiated adjustments

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

Topic #8417

# Voiding Claims

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

# Reimbursement

# 5

**Archive Date:04/01/2024**

# Reimbursement: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.

## 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 #16697

# Access Payments

Certain inpatient hospital and outpatient hospital claims receive add-on payments called access payments. Criteria for determining whether a claim receives an access payment include claim type, paid amount, and member information. Claims for childless adults enrolled in Wisconsin Medicaid or BadgerCare Plus are ineligible for access payments (childless adults are identified by ForwardHealth via their medical status codes).

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 #15217

# EAPG Reimbursement Methodology

ForwardHealth uses the EAPG (Enhanced Ambulatory Patient Groups) system software to classify and calculate reimbursement for outpatient hospital services. The Enhanced Ambulatory Patient Groups used in the EAPG system categorize the amount and type of resources used in various outpatient visits.

Under the EAPG system, ForwardHealth reimburses hospital providers for outpatient hospital services based on the quantity and type of services they provide. The system ensures that both low- and high-cost services are reimbursed appropriately.

ForwardHealth reimbursement of outpatient hospital services under the EAPG system is a packaged reimbursement, similar to

DRGs (Diagnosis Related Groups) for inpatient hospital services. Rather than being grouped by diagnosis and surgical codes, however, EAPGs are grouped by HCPCS (Healthcare Common Procedure Coding System) or CPT (Current Procedural Terminology) procedure codes.

The EAPG payment methodology pays different amounts for outpatient hospital services based on the resources required for each visit; it provides greater reimbursement for high-intensity services and relatively less reimbursement for low-intensity services. It also allows for greater payment homogeneity for comparable services across all outpatient hospital settings.

# Classification of Services

The EAPG system classifies EAPGs into one of the following types:

- Significant procedure — a normally scheduled procedure that constitutes the reason for the visit and dominates the time and resources expended during the visit
- Medical visit — a visit during which medical treatment was received but no significant procedure was performed (One example of a medical visit would be a preventive care visit.)
- Ancillary service — the term "ancillary service" is used to refer to both ancillary tests and ancillary procedures
    - An ancillary test is a test ordered by the primary physician to assist in patient diagnosis or treatment.
    - An ancillary procedure is a procedure that increases but does not dominate the time and resources expended during the visit.

# Rate Setting

Rates for use in the EAPG system are posted on the Hospital Weights and Rates page of the ForwardHealth Portal, accessed via the Provider-specific resources link in the Provider area of the Portal.

A rate is determined for each hospital. This rate is multiplied by the appropriate EAPG weight to determine reimbursement.

# Packaging

Using the EAPG system, ForwardHealth packages some, but not necessarily all, ancillary services; this simply means these services are included in the EAPG payment rate for a significant procedure or medical visit, rather than being separately reimbursed. For example, a chest X-ray may be packaged into the payment for a pneumonia visit. Although the detail of the packaged ancillary shows an allowed amount of $0, the packaging of ancillary services does not imply that there is no payment associated with the packaged ancillary. The cost of the packaged ancillary is included in the payment amount for the significant procedure or medical visit EAPG.

The ancillary services to be packaged are selected primarily on clinical grounds, as established by the EAPG system. Thus, only ancillaries that are clinically expected to be a routine part of the specific procedure or medical visit are packaged.

## Ancillary Services That Are Not Separately Reimbursable

Ancillary services that are not separately reimbursable will be denied if the primary procedure is denied and there is no significant procedure or medical visit to which the ancillary service can be packaged.

# Weight

The EAPG system examines the revenue code along with the procedure code and, if applicable, the diagnosis code and gender in order to assign each detail line an EAPG, along with other relevant values (weights, packaging flags, discounting percentages, etc.). Each EAPG carries a "weight" based on the group's average cost, from which appropriate payment levels are established.

## Version Indicator

ForwardHealth will post the current version number of the EAPG software in use on the Inpatient DRG Weights and Outpatient EAPG Weights and Inpatient and Outpatient Hospital Rates page of the Portal. For purposes of reimbursement, the version indicator will be determined using the header "from" dates of service entered on the claim.

## Multiple Significant Procedure Discounting

When multiple significant procedures are performed by the same provider for the same member during the same visit, ForwardHealth reimburses the first significant procedure at 100 percent of the allowed amount, the second at 50 percent, and any subsequent procedures at 25 percent. The significant procedure the highest weight on the claim is reimbursed as the first significant procedure, the next highest is reimbursed as the second significant procedure, etc.

## Bilateral Discounting

When a bilateral procedure is indicated on a detail by the use of modifier 50 (Bilateral procedure), ForwardHealth will reimburse the procedure at 150 percent of the allowed amount; that is, 100 percent for the first procedure and 50 percent for the second.

## Repeat Ancillary Discounting

When non-routine ancillary services (as determined by the EAPG system) are repeated by the same provider on the same DOS for the same member, ForwardHealth will reimburse these items as follows: 100 percent of the allowed amount for the first ancillary item, 50 percent for the second, and 25 percent for any subsequent items.

Topic #8117

# Electronic Funds Transfer

EFT (electronic funds transfer) allows ForwardHealth to directly deposit payments into a provider's designated bank account for a more efficient delivery of payments than the current process of mailing paper checks. EFT is secure, eliminates paper, and reduces the uncertainty of possible delays in mail delivery.

Only in-state and border-status providers who submit claims and MCOs (managed care organizations) are eligible to receive EFT payments.

## Provider Exceptions

EFT payments are not available to the following providers:

- In-state emergency providers
- Out-of-state providers
- Out-of-country providers
- SMV (specialized medical vehicle) providers during their provisional enrollment period

## Enrolling in Electronic Funds Transfer

A ForwardHealth Portal account is required to enroll into EFT as all enrollments must be completed via a secure Provider Portal account or a secure MCO Portal account. Paper enrollments are not accepted. A separate EFT enrollment is required for each financial payer a provider bills.

Providers who do not have a Portal account may Request Portal Access online. Providers may also call the Portal Helpdesk for assistance in requesting a Portal account.

The following guidelines apply to EFT enrollment:

- Only a Portal Administrator or a clerk that has been assigned the "EFT" role on the Portal may complete the EFT enrollment information.
- Organizations can revert back to receiving paper checks by disenrolling in EFT.
- Organizations may change their EFT information at any time.
- Organizations will continue to receive their Remittance Advice as they do currently.

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

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

## Recoupment and Reversals

Enrollment in EFT does not change the current process of recouping funds. Overpayments and recoupment of funds will continue to be conducted through the reduction of payments.

*Note:* Enrolling in EFT does not authorize ForwardHealth to make unauthorized debits to the provider's EFT account; however, in some instances an EFT reversal of payment may be necessary. For example, if the system generates a payment twice or the amount entered manually consists of an incorrect value (e.g., a decimal point is omitted creating a $50,000 keyed value for a $500 claim), a reversal will take place to correct the error and resend the correct transaction value. ForwardHealth will notify the designated EFT contact person of an EFT reversal if a payment is made in error due to a system processing or manual data entry error.

## Problem Resolution

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

Topic #14937

# Hospitals Providing End-Stage Renal Disease Services

With the exception of a limited number of emergency dialysis treatments, hospital providers are required to be separately enrolled as a Medicaid ESRD (end-stage renal disease) provider with a specialty of "hospital affiliated" to receive reimbursement for renal disease-related services provided to a member enrolled in BadgerCare Plus or Medicaid.

Hospitals submitting claims under their hospital enrollment (not under ESRD provider enrollment) may receive reimbursement for providing up to three emergency dialysis treatments for a member, per calendar year. Claims received for renal related services beyond this limit will be denied. These dialysis treatments are meant for emergency services only and not for a member with chronic renal failure.

## Medicaid-Enrolled Providers

ForwardHealth covers renal disease-related services provided to a member diagnosed with ESRD who is enrolled in BadgerCare

Plus or Medicaid. Providers enrolled in Medicaid as ESRD providers are eligible for reimbursement for renal disease-related services provided to members diagnosed with ESRD who are enrolled in BadgerCare Plus or Medicaid.

Topic #1367

# Payment Methods

The Hospital Inpatient and Outpatient State Plans are Wisconsin Medicaid's federally approved description of methods and standards for establishing payment rates to hospitals. The State Plans include all hospital inpatient and outpatient rate-setting methodologies. Each year, Wisconsin Medicaid may amend the State Plans. Hospitals are allowed an opportunity to comment on proposed amendments before Wisconsin Medicaid requests approval from the federal CMS (Centers for Medicare and Medicaid Services) for State Plan changes. Providers may obtain copies of the State Plan on the ForwardHealth Portal.

Wisconsin Medicaid reimburses outpatient hospital services using the EAPG (Enhanced Ambulatory Patient Groups) system, which groups services by HCPCS (Healthcare Common Procedure Coding System) or CPT (Current Procedural Terminology) procedure codes. If applicable, Wisconsin Medicaid also reimburses outpatient hospital providers for one access payment per visit and any other add-on payments as appropriate under the State Plan.

Only medically necessary covered services provided within the physical premises of a licensed hospital facility are eligible for outpatient hospital reimbursement. Medically necessary covered services provided in a facility that is not a licensed hospital facility or that are provided in a portion of a hospital facility that is not a licensed portion of a hospital are not covered as outpatient hospital services.

Topic #19957

# Policy Adjusters

Under the APR DRG (All Patient Refined Diagnosis Related Group) classification system, ForwardHealth uses policy adjusters to enhance payment for key Medicaid services relative to the base rate under the APR DRG system. Claims receiving enhanced payment have a policy adjuster greater than 1.0, while claims without enhanced payment have a policy adjuster equal to 1.0. This, in conjunction with the hospital base rate and APR DRG relative weight for the service, determines the base payment for the service under the APR DRG system. If more than one adjuster applies to a claim, the payment is based on the adjuster that provides the highest enhanced payment for that claim.

The following policy adjusters are used under the APR DRG system:

| Policy Adjuster | Claim Identification Basis | Factor |
|---|---|---|
| Normal Newborn | DRG | 1.80 |
| Transplant | DRG | 1.50 |
| Neonate | DRG | 1.30 |
| Level I Trauma | Provider trauma designation | 1.30 |
| Pediatric | Age (17 and under) | 1.20 |
| Remaining Service Line Adjusters* | DRG | 1.00 |

**Note:* Circulatory, Gastroenterology, Mental Health, Miscellaneous, Obstetrics, Respiratory, and Substance Abuse receive no adjustment (that is, multiplied by 1.00)

## 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.

# Copayment

Topic #1345

## Amounts

The copayment for outpatient hospital services is $3.00 per encounter (per visit) for BadgerCare Plus and Medicaid members.

Topic #21457

## Copay for Receiving Nonemergency Services in the Emergency Department

BadgerCare Plus members who are childless adults will be subject to an $8 copay requirement when the following conditions are met:

- The member's medical condition does not meet the prudent layperson's definition of emergency, per 42 C.F.R. (Code of Federal Regulations) § 438.114. The prudent layperson standard may be expanded to include (1) a psychiatric emergency involving a significant risk or serious harm to oneself or others, (2) a substance abuse emergency in which there is significant risk of serious harm to a member or others or there is likelihood of return to substance abuse without immediate treatment, or (3) emergency dental care, which is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever or trauma.
- The member sought and received additional post-stabilization care in the emergency department after being informed of the $8 copay and availability of alternative providers with lesser or no cost share.

Hospitals must check a member's enrollment status to determine if the member may be affected by the copay requirement. Before providing nonemergency services subject to the $8 copay, hospitals must:

- Provide a medical screening exam.
- Inform the member that if nonemergency services are provided, the member will owe an $8 copay.
- As required by 42 C.F.R. § 447.54, provide the name and location of an alternative provider able to provide services in a timely manner with a lesser cost share or no share.
- Per federal regulations, provide a referral to the alternative provider to coordinate scheduling.

The medical screening exam and any treatment needed to stabilize an emergency medical condition, as required by EMTALA (Emergency Medical Treatment and Labor Act), are not subject to the copay requirement.

If a member was not Medicaid eligible at the time of service but later retroactively receives Medicaid enrollment, they would not be subject to the $8 copay. This is because the provider would have been unable to identify the member's Medicaid eligibility at the time of service, and so could not inform the member about the copay or provide information about alternative providers.

Note: Providers may not deny services to a Wisconsin Medicaid or BadgerCare Plus member who fails to pay a copay.

Topic #231

## Exemptions

# Wisconsin Medicaid and BadgerCare Plus Copay Exemptions

According to Wis. Admin. Code § DHS 104.01(12)(a), and 42 C.F.R. (Code of Federal Regulations) § 447.56, providers are prohibited from collecting any copays from the following Medicaid and BadgerCare Plus members:

- Children under age 19
- American Indians or Alaskan Natives, regardless of age or income level, who are receiving or have ever received items and services either directly from an Indian health care provider or through referral under contract health services (Note: Until further notice, Wisconsin Medicaid and BadgerCare Plus will apply this exemption policy for **all** services regardless of whether a tribal health care provider or a contracted entity provides the service. Providers may not collect copay from any individual identified in the EVS (Enrollment Verification System) as an American Indian or Alaskan Native.)
- Terminally ill individuals receiving hospice care
- Nursing home residents
- Members enrolled in Wisconsin Well Woman Medicaid
- Individuals eligible through EE (Express Enrollment)

The following services do not require copays from any member enrolled in Wisconsin Medicaid or BadgerCare Plus:

- Behavioral treatment
- Care coordination services (prenatal and child care coordination)
- CRS (Community Recovery Services)
- Crisis intervention services
- CSP (community support program) services
- Comprehensive community services
- COVID-19-related care
- Emergency services for medical conditions that meet the prudent layperson standard (the prudent layperson standard is defined by 42 C.F.R. (Code of Federal Regulations) § 438.114, and may be expanded to include a psychiatric emergency involving a significant risk or serious harm to oneself or others, a substance abuse emergency in which there is significant risk of serious harm to a member or others or there is likelihood of return to substance abuse without immediate treatment, or emergency dental care, which is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever, or trauma)
- EMTALA (Emergency Medical Treatment and Labor Act)-required medical screening exam and stabilization services
- Family planning services and supplies, including sterilizations
- HealthCheck services
- Home care services (home health, personal care, and PDN (private duty nurse) services)
- Hospice care services
- Immunizations, including approved vaccines recommended to adults by the ACIP (Advisory Committee on Immunization Practices)
- Independent laboratory services
- Injections
- Pregnancy-related services
- Preventive services with an A or B rating* from the USPSTF (U.S. Preventive Services Task Force)**, including tobacco cessation services
- SBS (school-based services)
- Substance abuse day treatment services
- Surgical assistance
- Targeted case management services

Note: Providers may not impose cost sharing for health-care acquired conditions or other provider-preventable services as defined in federal law under 42 C.F.R. § 447.26(b).

* Providers are required to add CPT (Current Procedural Terminology) modifier 33 to identify USPSTF services that are not

specifically identified as preventive in nature. The definition for modifier 33 reads as follows:

> When the primary purpose of the service is the delivery of an evidence based service in accordance with a U.S. Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

Since many of the USPSTF recommendations are provided as part of a regular preventive medicine visit, ForwardHealth will not deduct a copayment for these services (CPT procedure codes 99381–99387 and 99391–99397).

[**] The USPSTF recommendations include screening tests, counseling, immunizations, and preventive medications for targeted populations. These services must be provided or recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice.

Topic #233

# Limitations

Providers should verify that they are collecting the correct copay for services as some services have monthly or annual copay limits. Providers may not collect member copays in amounts that exceed copay limits.

## Monthly Copay Limits

Per the federal limitations on premiums and cost sharing in 42 C.F.R. § 447.56(f), the combined amount of Medicaid premiums and copays a BadgerCare Plus or Medicaid member incurs each month may not exceed 5 percent of the member's monthly household income. To comply with federal limitations on premiums and cost sharing, ForwardHealth calculates each member's monthly premium and copay limit, which is a maximum allowable copay amount based on monthly income, for individual members. Members within the same household may have different individual copay limits, and children under age 19 are exempt from copays.

Providers must determine whether or not a BadgerCare Plus or Medicaid member is exempt from paying copays or has reached their monthly copay limit by accessing the Enrollment Verification System and receiving the message "No Copay" in response to an enrollment query.

### Member Notification

Each member receives a letter in the mail that states their individual monthly copay limit. If a member has a change, such as a change in income or marital status, they will receive a letter with the updated individual monthly copay limit.

When a member reaches their monthly copay limit before the end of the month, they will receive a letter that informs them that they have met their copay limit for that month, and copays will resume on the first day of the following month.

### Copay Collection

Once a member meets their individual monthly copay limit, copays will no longer be deducted from the provider's reimbursement. This is true even if subsequent claim adjustments reduce the member's incurred copay amount to below their monthly limit. **Providers may not collect copays from members who have met their individual monthly copay limit.**

Topic #237

# Refund/Collection

If a provider collects a copayment before providing a service and BadgerCare Plus does not reimburse the provider for any part of the service, the provider is required to return or credit the entire copayment amount to the member.

If BadgerCare Plus deducts less copayment than the member paid, the provider is required to return or credit the remainder to the member. If BadgerCare Plus deducts more copayment than the member paid, the provider may collect the remaining amount from the member.

Topic #239

# Requirements

Federal law permits states to charge members a copayment for certain covered services. Providers are required to request copayments from members. Providers may not deny services to a Wisconsin Medicaid or BadgerCare Plus member who fails to make a copayment.

Wis. Stat. § 49.45(18) requires providers to make a reasonable attempt to collect copayment from the member unless the provider determines that the cost of collecting the copayment exceeds the amount to be collected.

## Reimbursement Not Available

Topic #1344

# Reimbursement Not Available

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

Under Wis. Admin. Code §§ DHS 107.08(4)(a)4 and DHS 107.08(4)(a)6, the following are not reimbursable as outpatient hospital services:

- Inpatient and outpatient services for the same member, on the same DOS (date of service), unless the member is admitted to a hospital other than the facility providing the outpatient care.
- Hospital laboratory, diagnostic, radiology, and imaging tests not ordered by a physician, except in emergencies.

## Experimental Services

As specified in Wis. Admin. Code § DHS 107.035, Wisconsin Medicaid does not reimburse outpatient hospital experimental services. Wisconsin DHS (Department of Health Services) considers a service experimental when the procedure is not generally recognized by the professional medical community as effective or proven for the condition for which it is being used.

DHS may consider a service experimental in one setting or institution, but effective, proven, and nonexperimental in another setting, depending on the facility's experience and capabilities.

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.

## Pay for Performance Initiative

Topic #13317

# Hospital Assessment Pay for Performance Program

The Wisconsin DHS (Department of Health Services) reserves money for Wisconsin acute care, children's, and rehabilitation hospitals that meet certain performance targets. This performance-based payment system is the Assessment P4P (Pay for Performance) program.

The Hospital P4P Guide includes an overview of the Assessment P4P program, measure specifications, and program/bonus methodology.

# Member Information

# 6

**Archive Date:04/01/2024**

# Member Information:Enrollment Categories

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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, Gainwell Technologies.

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
- Foster care or adoption assistance 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.

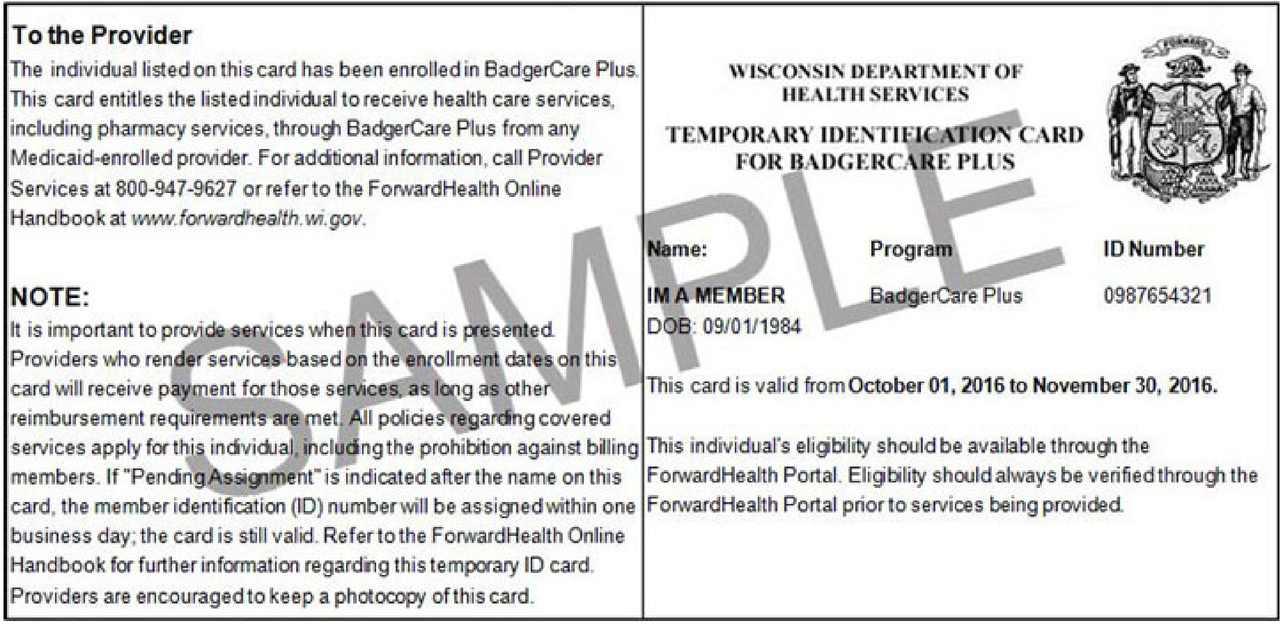
A member determined eligible through the real-time eligibility process will receive a temporary ID (identification) card for BadgerCare Plus and/or Family Planning Only Services. Each member will get their own card, and each card will include the member's ForwardHealth ID number. The temporary ID card 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



SAMPLE

**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.

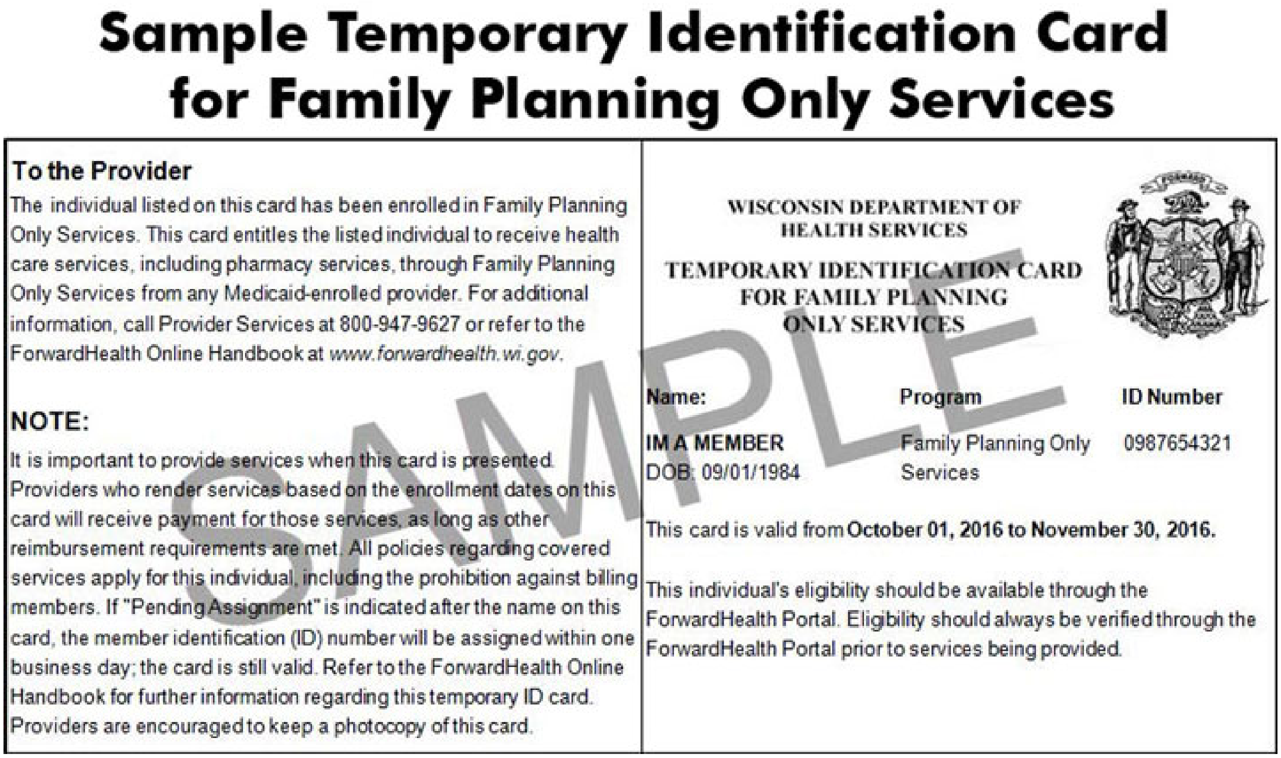
WISCONSIN DEPARTMENT OF
HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD
FOR BADGERCARE PLUS

| **Name:** | **Program** | **ID Number** |
|---|---|---|
| **IM A MEMBER**<br>DOB: 09/01/1984 | BadgerCare Plus | 0987654321 |

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

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



**Sample Temporary Identification Card for Family Planning Only Services**

**To the Provider**

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

**NOTE:**

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

WISCONSIN DEPARTMENT OF
HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD
FOR FAMILY PLANNING
ONLY SERVICES

| **Name:** | **Program** | **ID Number** |
|---|---|---|
| IM A MEMBER<br>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.

SAMPLE

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.

# 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).

## Digital ForwardHealth Identification Cards

Members can access digital versions of their ForwardHealth cards on the MyACCESS mobile app. Members are able to save PDFs and print out paper copies of their cards from the app. The digital and paper printout versions of the cards are identical to the physical cards for the purposes of accessing Medicaid-covered services. All policies that apply to the physical cards mailed by ForwardHealth to the member also apply to the digital or printed versions that members may present.

A member may still access their digital ForwardHealth card on the MyACCESS app when they are no longer enrolled. The MyACCESS app will display a banner message noting that the member is not currently enrolled in a ForwardHealth program. Providers should always verify enrollment with Wisconsin's EVS.

## Identification Number Changes

Some providers may question whether services should be provided if a member's 10-digit identification number on 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.

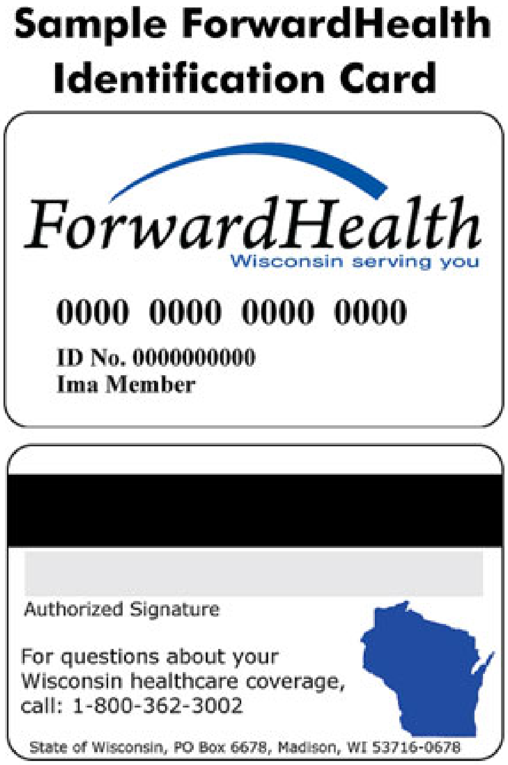
## Managed Care Organization Enrollment Changes

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.

**Sample Digital ForwardHealth Identification Card**

←
Digital ForwardHealth card

You may be asked to show the card below at each visit with a doctor or health care provider. In addition, you may be asked to give the ID number listed on the card



**Sample ForwardHealth Identification Card**

ForwardHealth
Wisconsin serving you

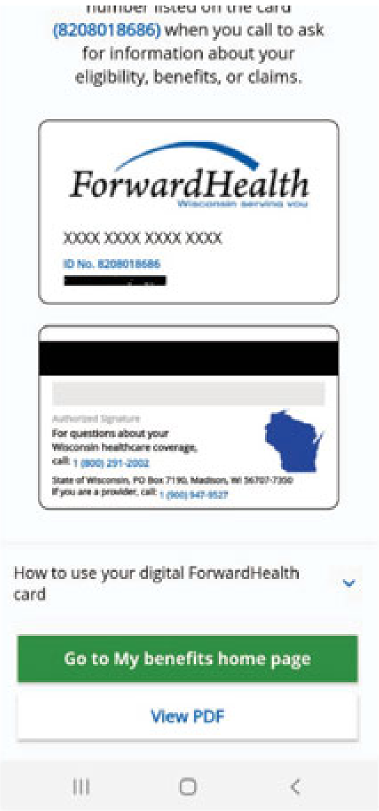
0000 0000 0000 0000

ID No. 0000000000
Ima Member

Authorized Signature

For questions about your
Wisconsin healthcare coverage,
call: 1-800-362-3002

State of Wisconsin, PO Box 6678, Madison, WI 53716-0678



number listed on the card (8208018686) when you call to ask for information about your eligibility, benefits, or claims.

ForwardHealth
Wisconsin serving you

XXXX XXXX XXXX XXXX

ID No. 8208018686
[redacted]

Authorized Signature

For questions about your
Wisconsin healthcare coverage,
call: 1 (800) 291-2002

How to use your digital ForwardHealth card
Go to My benefits home page
View PDF

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.

# 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.

# 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

# 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 Wisconsin Medicaid at the time of birth. Timely reporting of newborns ensures that there will be no delay in receiving important services.

Note: "Mother" refers to the person who gave birth to the newborn. Providers should only report newborns born to the mother who is enrolled in BadgerCare Plus or Wisconsin Medicaid.

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 Wisconsin Medicaid at the time of birth.

For privacy and security purposes, providers should **not** submit newborn reports via email.

## Newborn Reporting Wizard

Providers may report newborn births by using the newborn reporting wizard located on the ForwardHealth Portal. They should start by searching for the mother using one of the following criteria:

- Member ID
- Social Security number (no dashes) and date of birth (dd/mm/yyyy)
- Member first name, last name, and date of birth (dd/mm/yyyy)

Required newborn information includes the following:

- First name, or if not available, Boy or Girl
- Middle initial (if applicable)
- Last name
- Gender
- Date of birth (in mm/dd/yyyy)
- Date of death (in mm/dd/yyyy [if applicable])
- Social Security number (no dashes)
- Indication if the baby is entering foster care, adoption, or Safe Haven
- Indication if newborn's address is different than the mother's
- Phone number (if a phone type is selected)
- Full address if the address is different from the mother's and the newborn is not going to foster care, adoption, or Safe Haven
- Indication if newborn weight is less than 1200 grams
- Newborn weight (if applicable)
- Gestational age (weeks)

Providers may select the Multiple Births option to report up to nine multiple births in the online newborn reporting wizard.

All required fields must be completed. If not, the newborn report cannot be submitted online.

Newborn reports should be submitted only for babies born to women enrolled in BadgerCare Plus or Wisconsin Medicaid.

Refer to the Newborn Reporting User Guide on the User Guides page of the Portal for more detailed instructions.

## Fax or Mail

Providers may report the birth of a baby by submitting the Newborn Report form by fax or by mail 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 on 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 email.

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 Wisconsin 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 Wisconsin Medicaid

If a mother was not enrolled in BadgerCare Plus or Wisconsin 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 Wisconsin 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 (for example, heart, liver), or ongoing treatment for chronic conditions where there is no evidence of an acute emergent state. For the purposes of this policy, services for ESRD (end-stage renal disease) and all labor and delivery are considered emergency services.

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 (02/2009)) 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 who are eligible for BadgerCare Plus or Wisconsin Medicaid benefits will have their eligibility suspended during their detention period. During the suspension, ForwardHealth will only cover inpatient services received while the member is outside of jail or prison for 24 hours or more.

*Note:* "Detained by legal process" means a person who is incarcerated because of law violation or alleged law violation, which includes misdemeanors, felonies, delinquent acts, and day-release prisoners. Inmates who are released from jail under the Huber Program to return home to care for their minor children may be eligible for full benefit BadgerCare Plus or Wisconsin Medicaid without suspension.

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 and are not subject to eligibility suspension. 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) or county jail oversee 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 #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 (for example, 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 (02/2014)) 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.

## 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 (that is, 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 (for example, 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 Kepro. Kepro may be contacted by phone at 877-719-3123, by fax at 800-881-5573, or by mail at the following address:

Pharmacy Services Lock-In Program
c/o Kepro
PO Box 3570
Auburn AL 36831-3570

## 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 their 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 (03/2023)) 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 they have 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 they have 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 their 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 Kepro.
- 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 Kepro 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.

# 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

# Presumptive Eligibility Determination

Topic #16799

## Covered Services

Effective with the date of determination (i.e., the date an application that meets the PE (presumptive eligibility) criteria is submitted), individuals are eligible to receive coverage under BadgerCare Plus and Wisconsin Medicaid as indicated below.

### Pregnant Women

Pregnant women are eligible for ambulatory pregnancy-related care as outlined in the Express Enrollment for Children and Pregnant Women service area. The member is required to be fully enrolled for coverage of inpatient services, including the delivery.

### Family Planning Only Services

Individuals who are determined eligible for the Family Planning Only Services benefit will be eligible for family planning and family planning-related services only.

### All Other Populations

All other populations indicated below will be eligible for Medicaid and BadgerCare Plus coverage:

- Children
- Parents and caretakers
- Childless adults
- Women with breast and cervical cancer

# Coordination of Benefits

# 7

**Archive Date:04/01/2024**

# Coordination of Benefits:Other Coverage Information

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Topic #4940

## After Reporting Discrepancies

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

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

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

Topic #4941

## Coverage Discrepancies

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

Topic #609

## Insurance Disclosure Program

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

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

Topic #610

## Maintaining Accurate and Current Records

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

- Insurance Disclosure program
- Providers who submit an Commercial Other Coverage Discrepancy Report (F-01159 (04/2017)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/2018)) form
- Member certifying agencies

- Members

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

Topic #4942

# Reporting Discrepancies

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

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

## 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 (04/2017)) form. Unless the service does not require other health insurance billing, the provider should allow at least two weeks before proceeding to Step 2.

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

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

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

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

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

**Step 3. Identify Assignment of Commercial Health Insurance Benefits**

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

The provider should proceed in one of the following ways:

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

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

**Step 4. Bill Commercial Health Insurance and Follow Up**

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

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

**Step 5. Submit Claim to ForwardHealth**

**If only partial reimbursement is received, if the correct and complete claim is denied by commercial health insurance,**

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

Topic #18497

# Explanation of Medical Benefits Form Requirement

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

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

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

Use of the ForwardHealth Explanation of Medical Benefits form is mandatory; providers are required to use an exact copy. ForwardHealth will not accept alternate versions (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 #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:<br>- The member denied coverage or will not cooperate.<br>- The provider knows the service in question is not covered by the carrier.<br>- The member's commercial health insurance failed to respond to initial and follow-up claims.<br>- Benefits are not assignable or cannot get assignment.<br>- 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, QTT (qualified treatment trainee) level, or certified psychotherapist 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 #664

## Acceptance of Assignment

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

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

Topic #666

## Claims Denied for Errors

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

Topic #668

## Claims Processed by Commercial Health Insurance That Is Secondary to Medicare

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

Topic #670

## Claims That Do Not Require Medicare Billing

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

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

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

Topic #704

# Claims That Fail to Cross Over

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

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

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

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

Topic #667

# Claims for Services Denied by Medicare

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

Topic #671

# Crossover Claims

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

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

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

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

- Automatic crossover claims

- Provider-submitted crossover claims

## Automatic Crossover Claims

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

Claims will be forwarded if the following occur:

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

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

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

## Provider-Submitted Crossover Claims

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

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

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

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

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

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

- Paper claim form

Topic #672

# Definition of Medicare

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

Medicare coverage is divided into four parts:

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

Topic #684

# Dual Eligibles

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

Dual eligibles may receive coverage for the following:

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

Topic #669

# Exhausting Medicare Coverage

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

## Adjustment Request for Crossover Claim

The provider may submit a paper or electronic adjustment request. If submitting a paper Adjustment/Reconsideration Request (F-13046 (08/2015)) form, the provider should complete and submit the Explanation of Medical Benefits form, as applicable.

# Provider-Submitted Crossover Claim

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

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

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

- For electronic claims, indicate the Medicare payment.
- For paper claims, complete the Explanation of Medical Benefits form.

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

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

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

# Claim for Services Denied by Medicare

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

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

# Crossover Claim Previously Reimbursed

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

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

In these situations, the provider should proceed as follows:

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

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

Topic #687

# Medicare Advantage

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

ForwardHealth has identified services requiring Medicare Advantage billing.

## Paper Crossover Claims

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

## Reimbursement Limits

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

Topic #20677

# Medicare Cost

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

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

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

Topic #688

# Medicare Disclaimer Codes

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

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

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

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

- The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis).

## Documentation Requirements

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

Topic #8457

# Medicare Late Fees

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

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

## Resubmitting Medicare Crossover Claims with Late Fees

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

### Paper Claim Submissions

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

### Electronic Claim Submissions

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

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

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

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

Topic #689

# Medicare Provider Enrollment

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

## Services for Dual Eligibles

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

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

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

## Services for Qualified Medicare Beneficiary-Only Members

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

Topic #690

# Medicare Retroactive Eligibility — Member

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

Topic #1366

# Outpatient Hospital Crossover Claims

Under the EAPG (Enhanced Ambulatory Patient Groups) system, Wisconsin Medicaid will reimburse providers the Medicare coinsurance cost share at the lesser of the difference between the Medicare allowed amount and paid amount or the difference between the Medicaid allowed amount and the Medicare paid amount. The Medicare deductible will continue to be reimbursed in full.

Outpatient hospital providers submitting Medicare crossover claims should note the following:

- Providers adjusting or resubmitting outpatient hospital crossover claims are required to indicate Medicare adjudication amounts (e.g., Medicare allowed, paid, coinsurance, copayment, and deductible amounts) at the detail level.
- For those details that do not include HCPCS (Healthcare Common Procedure Coding System) procedure codes on a Medicare crossover claim, ForwardHealth will show an allowed amount of $0 for the detail. If procedure codes are available for these details, the provider may adjust the claim to include this information.

- Providers who receive EOB (Explanation of Benefits) 273 for a denied detail or claim on an RA (Remittance Advice) or an 835 (835 Health Care Claim Payment/Advice) transaction may resubmit the claim to be considered for reimbursement.
- When adjudicating reimbursement for therapy crossover claims, the maximum allowable fee will be used in the reimbursement calculation.

Topic #692

# Qualified Medicare Beneficiary-Only Members

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

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

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

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

Topic #686

# Reimbursement for Crossover Claims

## Professional Crossover Claims

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

Total payment for a Medicare Part B-covered service (i.e., any amount paid by other health insurance sources, any copayment or spenddown amounts paid by the member, and any amount paid by Wisconsin Medicaid) may not exceed the Medicare-allowed amount. Therefore, Medicaid reimbursement for coinsurance or copayment of a Medicare Part B- covered service is the lesser of the following:

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

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

| **Reimbursement for Coinsurance or Copayment of Medicare Part B-Covered Services** | | | |
|---|---|---|---|
| **Explanation** | **Example** | | |
| | **1** | **2** | **3** |
| Provider's billed amount | $120 | $120 | $120 |
| Medicare-allowed amount | $100 | $100 | $100 |
| Medicaid-allowed amount (e.g., maximum allowable fee) | $90 | $110 | $75 |

| | | | |
|---|---|---|---|
| Medicare payment | $80 | $80 | $80 |
| Medicaid payment | $10 | $20 | $0 |

## Outpatient Hospital Crossover Claims

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

## Inpatient Hospital Services

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

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

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

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

**Reimbursement for Medicare Part A-Covered Inpatient Hospital Services Provided To Dual Eligibles**

| Explanation | Example | | |
|---|---|---|---|
| | 1 | 2 | 3 |
| Provider's billed amount | $1,200 | $1,200 | $1,200 |
| Medicare-allowed amount | $1,000 | $1,000 | $1,000 |
| Medicaid-allowed amount (e.g., diagnosis-related group or per diem) | $1,200 | $750 | $750 |
| Medicare-paid amount | $1,000 | $800 | $500 |
| Difference between Medicaid-allowed amount and Medicare-paid amount | $200 | ($-50) | $250 |
| Medicare coinsurance, copayment and deductible | $0 | $200 | $500 |
| Medicaid payment | $0 | $0 | $250 |

## Nursing Home Crossover Claims

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

Topic #770

# Services Requiring Medicare Advantage Billing

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

- Ambulance services
- ASC (ambulatory surgery center) services

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

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

ForwardHealth has identified services requiring commercial health insurance billing.

# Provider-Based Billing

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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.

## Accessing Provider-Based Billing Summary Reports

Providers can retrieve provider-based billing summary reports through the Portal by logging in to their secure provider Portal account. Once logged in, providers can click the Provider Based Bills (PBB) link located in the Quick Links box of the Providers area of the Portal to access the Provider Based Billing page. This page has links for the provider to download provider-based summary reports in .csv or .pdf format.

Refer to the Provider-Based Billing Retrieval User Guide for step-by-step instructions on how to access the Provider Based Billing page and download provider-based summary reports.

Note: ForwardHealth also sends the paper provider-based billing summary report to the provider's "mail to" address on file in the Portal.

The provider-based billing process runs monthly on the first full weekend of every month and files are available once the process is completed.

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<br>Claims and Adjustments<br>313 Blettner Blvd<br>Madison WI 53784 |
| The provider discovers that the member's other coverage information (that is, enrollment dates) reported by the EVS is invalid. | - A Commercial Other Coverage Discrepancy Report (F-01159 (04/2017)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/2018)) form.<br>- 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.<br>Send the claim to the following address:<br>ForwardHealth<br>Claims and Adjustments<br>313 Blettner Blvd<br>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).<br>- The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. | ForwardHealth<br>Claims and Adjustments<br>313 Blettner Blvd<br>Madison WI 53784 |

| | | |
|---|---|---|
| | • The amount received from the other health insurance source on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. | |
| 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).<br>• 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<br>Claims and Adjustments<br>313 Blettner Blvd<br>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).<br>• The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. | ForwardHealth<br>Claims and Adjustments<br>313 Blettner Blvd<br>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).<br>• A Timely Filing Appeals Request (F-13047 (08/2015)) form according to normal timely filing appeals procedures. | ForwardHealth<br>Timely Filing<br>Ste 50<br>313 Blettner Blvd<br>Madison WI 53784 |
| The provider discovers that the member's other coverage information (that is, enrollment dates) reported by the EVS is invalid. | • A Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form.<br>• **After** using the EVS to verify that the member's other coverage information has been updated, include both of the following:<br>◦ A claim (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.<br>Send the timely filing appeals request to the following address: |

| | | |
|---|---|---|
| | ¡ A Timely Filing Appeals Request form according to normal timely filing appeals procedures. | ForwardHealth<br>Timely Filing<br>Ste 50<br>313 Blettner Blvd<br>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).<br>- Indicate the amount received from the commercial health insurance on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.<br>- A Timely Filing Appeals Request form according to normal timely filing appeals procedures. | ForwardHealth<br>Timely Filing<br>Ste 50<br>313 Blettner Blvd<br>Madison WI 53784 |
| The other health insurance source denies the provider-based billing claim. | - A claim.<br>- The appropriate other insurance indicator or Medicare disclaimer code on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.<br>- A Timely Filing Appeals Request form according to normal timely filing appeals procedures.<br>- The Provider-Based Billing Summary.<br>- Documentation of the denial, including any of the following:<br>¡ Remittance information from the other health insurance source.<br>¡ A written statement from the other health insurance source identifying the reason for denial.<br>¡ A letter from the other health insurance source indicating a policy termination date that proves that the other health insurance source paid the member.<br>¡ 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. | ForwardHealth<br>Timely Filing<br>Ste 50<br>313 Blettner Blvd<br>Madison WI 53784 |

| | | |
|---|---|---|
| | - The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary. | |
| The commercial health insurance carrier does not respond to an initial and follow-up provider-based billing claim. | - A claim (do **not** use the provider-based billing summary).<br>- The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.<br>- A Timely Filing Appeals Request form according to normal timely filing appeals procedures. | ForwardHealth<br>Timely Filing<br>Ste 50<br>313 Blettner Blvd<br>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.<br>- Indication that the EVS no longer reports the member's other coverage. | ForwardHealth<br>Provider-Based Billing<br>PO Box 6220<br>Madison WI 53716-0220<br>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.<br>- One of the following:<br>  - The name of the person with whom the provider spoke and the member's correct other coverage information. | ForwardHealth<br>Provider-Based Billing<br>PO Box 6220<br>Madison WI 53716-0220<br>Fax 608-221-4567 |

| | | |
|---|---|---|
| | - A printed page from an enrollment website containing the member's correct other coverage information. | |
| The other health insurance source reimburses or partially reimburses the provider-based billing claim. | - The Provider-Based Billing Summary.<br>- A copy of the remittance information received from the other health insurance source.<br>- 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.<br>- A copy of the Explanation of Medical Benefits form, as applicable.<br><br>*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. | ForwardHealth<br>Provider-Based Billing<br>PO Box 6220<br>Madison WI 53716-0220<br>Fax 608-221-4567 |
| The other health insurance source denies the provider-based billing claim. | - The Provider-Based Billing Summary.<br>- Documentation of the denial, including any of the following:<br>  - Remittance information from the other health insurance source.<br>  - A letter from the other health insurance source indicating a policy termination date that precedes the DOS.<br>  - Documentation indicating that the other health insurance source paid the member.<br>  - A copy of the insurance card or other | ForwardHealth<br>Provider-Based Billing<br>PO Box 6220<br>Madison WI 53716-0220<br>Fax 608-221-4567 |

| | | |
|---|---|---|
| | documentation from the other health insurance source that indicates the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage.<br>A copy of the Explanation of Medical Benefits form, as applicable.<br>The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary. | |
| The other health insurance source fails to respond to the initial **and** follow-up provider-based billing claim. | The Provider-Based Billing Summary.<br>Indication that no response was received by the other health insurance source.<br>Indication of the dates that the initial and follow-up provider-based billing claims were submitted to the other health insurance source. | ForwardHealth<br>Provider-Based Billing<br>PO Box 6220<br>Madison WI 53716-0220<br>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.

# Resources

# 8

**Archive Date:04/01/2024**

# Resources: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.

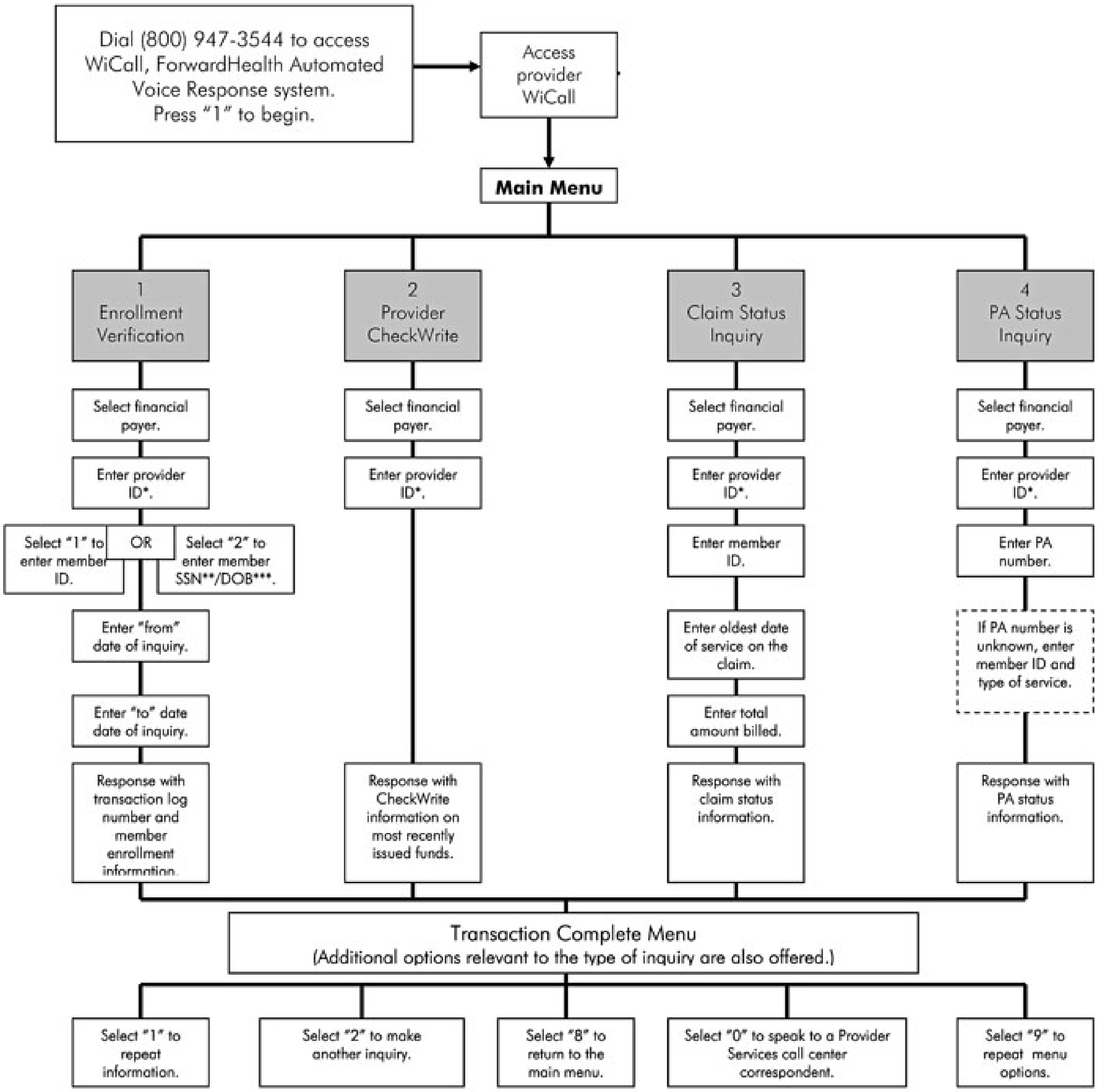
*Note:* PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

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


Dial (800) 947-3544 to access WiCall, ForwardHealth Automated Voice Response system. Press "1" to begin.
Access provider WiCall
Main Menu
1 Enrollment Verification
2 Provider CheckWrite
3 Claim Status Inquiry
4 PA Status Inquiry
Select financial payer.
Enter provider ID*.
Select "1" to enter member ID.
OR
Select "2" to enter member SSN**/DOB***.
Enter "from" date of inquiry.
Enter "to" date date of inquiry.
Response with transaction log number and member enrollment information.
Response with CheckWrite information on most recently issued funds.
Enter member ID.
Enter oldest date of service on the claim.
Enter total amount billed.
Response with claim status information.
Enter PA number.
If PA number is unknown, enter member ID and type of service.
Response with PA status information.
Transaction Complete Menu
(Additional options relevant to the type of inquiry are also offered.)
Select "1" to repeat information.
Select "2" to make another inquiry.
Select "8" to return to the main menu.
Select "0" to speak to a Provider Services call center correspondent.
Select "9" to repeat menu options.

* 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

# 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

# Copay Information

## No Copay

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

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

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

## Copay

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

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

## Non-Emergent Copay

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

- The name of the benefit plan
- The member's enrollment dates
- The message, "Member Eligible for Non-Emergent Copay" or "Eligible for Non-Emergent Copay"

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

Topic #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 copays (BadgerCare Plus and Medicaid members only)

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

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

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

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

Topic #4900

# Entering Dates of Service

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

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

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

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

Topic #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 or displays a digital ForwardHealth Card on the MyACCESS app.

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

# Updates

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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 using both email subscription and secure Portal messaging to notify providers of newly released ForwardHealth Updates. ForwardHealth also uses electronic messaging to communicate training opportunities and other timely information.

## Secure Portal Messages

Providers who have established a secure ForwardHealth Portal account automatically receive messages from ForwardHealth in their secure Portal Messages inbox.

## E-mail Subscription Messages

Providers and other interested parties may register to receive e-mail subscription notifications. When registering for e-mail subscription, providers and other interested parties are able to select, by program (for example, Wisconsin Medicaid, BadgerCare Plus, ADAP (Wisconsin AIDS Drug Assistance Program), or WCDP (Wisconsin Chronic Disease Program)), provider type (for example, physician, hospital, DME (durable medical equipment) vendor), and/or specific area 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. 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.
3. Enter the e-mail address again in the Confirm E-Mail field.

4. 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.
5. 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.
6. 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.
7. 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.

# Contact Information

Topic #476

## Member Services

Providers should refer ForwardHealth members with questions to Member Services. The telephone number for Member Services is for member use only.

Topic #473

## Professional Field Representatives

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

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

- Dental providers
- Milwaukee County

### Provider Education

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

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

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

### Additional Inquiries

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

- Claims, including discrepancies regarding enrollment verification and claim processing
- PES (Provider Electronic Solutions) claims submission software
- Claims processing problems that have not been resolved through other channels (for example, phone or written correspondence)
- Referrals by a Provider Services phone correspondent
- Complex issues that require extensive explanation

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

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

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

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

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

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

- Verifying covered services

## Information to Have Ready

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

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

## Call Center Representatives

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

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

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

## Walk-in Appointments

Walk-in appointments offer face-to-face assistance for providers at the Provider Services office. Providers must schedule an appointment in advance by contacting Provider Services at 800-947-9627. Appointments for in-person provider assistance are available Monday through Friday, 7:30 a.m.-4:00 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 (07/2012)) form. The Written Correspondence Inquiry form may be photocopied or downloaded via a link from the Portal. Written correspondence should be sent to the following address:

ForwardHealth

Provider Services Written Correspondence
313 Blettner Blvd
Madison WI 53784

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

Topic #4456

# Resources Reference Guide

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

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

<table>
<tr><td colspan="3">accounts, registrations, passwords, and submissions through the Portal.</td></tr>
<tr><th>Electronic Data Interchange Helpdesk</th><th>866-416-4979</th><th>Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central time)*</th></tr>
<tr><td colspan="3">For providers, including trading partners, billing services, and clearinghouses with technical questions about the following:<br>- Electronic transactions<br>- Companion documents<br>- PES (Provider Electronic Solutions) software</td></tr>
<tr><th>Managed Care Provider Appeals</th><th>800-760-0001, Option 1</th><th>Monday through Friday,<br>7 a.m. to 6 p.m.<br>(Central time)*</th></tr>
<tr><td colspan="3">To assist BadgerCare Plus/Medicaid SSI (Supplemental Security Income) HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) providers with questions regarding their appeal status and other general managed care provider appeal information.</td></tr>
<tr><th>Managed Care Ombudsman Program</th><th>800-760-0001</th><th>Monday through Friday,<br>7 a.m. to 6 p.m.<br>(Central time)*</th></tr>
<tr><td colspan="3">To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.</td></tr>
<tr><th>Member Services</th><th>800-362-3002</th><th>Monday through Friday,<br>8 a.m. to 6 p.m.<br>(Central time)*</th></tr>
<tr><td colspan="3">To assist ForwardHealth members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.</td></tr>
<tr><th>Wisconsin AIDS Drug Assistance Program</th><th>800-991-5532</th><th>Monday through Friday,<br>8 a.m. to 4:30 p.m.<br>(Central time)*</th></tr>
<tr><td colspan="3">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.</td></tr>
</table>

*With the exception of state-observed holidays.

# Portal

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Topic #4743

# Acute and Primary Managed Care Portal

## Information and Functions Through the Portal

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

The following information is available through the Portal:

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

Topic #4904

# Claims and Adjustments Using the ForwardHealth Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, copy claims, and determine what claims are in "pay" status on the ForwardHealth Portal. Providers have the ability to search for and view the status of all their finalized claims, regardless of how they were submitted (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim through DDE (Direct Data Entry) through the secure Portal.

Topic #8524

# Conducting Revalidation Via the ForwardHealth Portal

Providers can conduct revalidation online via a secure revalidation area of the ForwardHealth Portal.

Topic #4345

# Creating a Provider Account

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

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

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

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

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

Topic #16737

# Demographic Maintenance Tool

The demographic maintenance tool allows providers to update information online that they are required to keep current with ForwardHealth. To access the demographic maintenance tool, providers need a ForwardHealth Portal account. After logging into their Portal account, providers should select the Demographic Maintenance link located in the Home Page box on the right side of the secure Provider home page.

Note: The Demographic Maintenance link will only display for administrative accounts or for clerk accounts that have been assigned the Demographic Maintenance role. The Account User Guide provides specific information about assigning roles.

The demographic maintenance tool contains general panels which are available to all or most providers as well as specific panels which are only available to certain provider types and specialties. The Demographic Maintenance Tool User Guide provides further information about general and provider-specific panels.

## Uploading Supporting Documentation

Providers can upload enrollment-related supporting documentation (e.g., licenses, certifications) using the demographic maintenance tool. Documents in the following formats can be uploaded:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg)
- PDF (Portable Document Format) (.pdf)

To avoid delays in processing, ForwardHealth strongly encourages providers to upload their documents.

## Submitting Information

After making **all** their changes, providers are required to submit their information in order to save it. After submitting information, providers will receive one of the following messages:

- "Your information was **updated** successfully." This message indicates that providers' files were immediately updated with the changed information.
- "Your information was **uploaded** successfully." This message indicates that ForwardHealth needs to verify the information before providers' files can be updated. Additionally, an Application Submitted panel will display and indicate next steps.

### Verification

ForwardHealth will verify changes within 10 business days of submission. If the changes can be verified, ForwardHealth will update providers' files. In some cases, providers may receive a Change Notification letter indicating what information ForwardHealth updated. Providers should carefully review the Provider File Information Change Summary included with the letter to verify the accuracy of the changes. If any of the changes are inaccurate, providers can correct the information using the demographic maintenance tool. Providers may contact Provider Services if they have questions regarding the letter.

Regardless of whether or not providers are notified that their provider files were updated, changed information is not considered approved until 10 business days after the information was changed. If the changes cannot be verified within 10 business days, ForwardHealth will notify providers by mail that their provider files were not updated, and providers will need to make corrections using the demographic maintenance tool.

Topic #4340

# Designating a Trading Partner to Receive 835 Health Care Claim Payment/Advice Transactions

Providers must designate a trading partner to receive their 835 (835 Health Care Claim Payment/Advice) transaction for ForwardHealth interChange.

Providers who wish to submit their 835 designation via the Portal are required to create and establish a provider account to have access to the secure area of the Portal.

To designate a trading partner to receive 835 transactions, providers must first complete the following steps:

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

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

Topic #5088

# Enrollment Verification

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

- The health care program(s) in which the member is enrolled
- Whether or not the member is enrolled in a state-contracted MCO (managed care organization)
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance
- Whether or not the member is enrolled in the Pharmacy Services Lock-In Program and the member's Lock-In pharmacy, primary care provider, and referral providers (if applicable)

Using the Portal to check enrollment may be more effective than calling WiCall or the EVS (Enrollment Verification System) (although both are available).

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

Topic #4338

# ForwardHealth Portal

Providers, members, trading partners, managed care programs, and partners have access to public **and** secure information through the ForwardHealth Portal.

The Portal has the following areas:

- Providers (public and secure)
- Trading Partners
- Members
- MCO (managed care organization)
- Partners

The secure Portal allows providers to conduct business and exchange electronic transactions with ForwardHealth. The public Portal contains general information accessible to all users. Members can access general health care program information and apply for benefits online.

Topic #4441

# ForwardHealth Portal Helpdesk

Providers and trading partners may call the ForwardHealth Portal Helpdesk with technical questions on Portal functions, including their Portal accounts, registrations, passwords, and submissions through the Portal.

Topic #4451

# Inquiries to ForwardHealth Via the Portal

Providers are able to contact Provider Services through the ForwardHealth Portal by clicking the Contact link and entering the relevant inquiry information, including selecting the preferred method of response (i.e., telephone call or email). Provider Services will respond to the inquiry by the preferred method of response indicated within five business days.

Topic #4400

# Internet Connection Speed

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

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

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

Topic #4351

# Logging in to the Provider Area of the Portal

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

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

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

Topic #5158

# Managed Care Organization Portal Reports

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

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

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

## Capitation Payment Listing Report

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

## Initial Enrollment Roster Report

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

## Final Enrollment Roster Report

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

## Other Reports

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

Topic #4744

# Members ForwardHealth Portal

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

Topic #4344

# Obtaining a Personal Identification Number

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

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

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

Providers may request a PIN by following these steps:

1. Go to the Portal.
2. Click on the "Providers" link or button.
3. Click the "Request Portal Access" link from the Quick Links box on the right side of the screen.
4. At the Request Portal Access screen, enter the following information:
    a. Health care providers are required to enter their NPI and click "Search" to display a listing of ForwardHealth

enrollments. Select the correct enrollment for the account. The taxonomy code, ZIP+4 code, and financial payer for that enrollment will be automatically populated. Enter the SSN (Social Security number) or TIN (Tax Identification Number).

b. Non-healthcare providers are required to enter their provider number, financial payer, and SSN or TIN. (This option should only be used by non-healthcare providers who are exempt from NPI requirements).

   The financial payer is one of the following:
   - Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and Senior Care.)
   - SSI (Supplemental Security Income)
   - WCDP (Wisconsin Chronic Disease Program)
   - The WWWP (Wisconsin Well Woman Program)

c. Click **Submit**.
d. Once the Portal Access Request is successfully completed, ForwardHealth will send a letter with the provider's PIN to the address on file.

Topic #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, chapters, and topics. 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 (for example, claims submission, procedure codes), which contain further detailed information in individual topics.

## Search Function

The Online Handbook has a search function that allows providers to search for a specific word, phrase, or topic number within a user type, program, service area, or throughout the entire Online Handbook.

Providers can access the 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 left to narrow the search by program and service area, if applicable. This is not needed if searching the entire Online Handbook.
4. Enter the word, phrase, or topic number you would like to search.
5. Select **Search within the options selected above** or **Search all handbooks, programs and service areas; or Search by Topic Number.**
6. Click **Search**.

## Saving Preferences

Providers can select Save Preferences when performing a search (by service area, section, chapter, topic number) and will receive confirmation that their preferences have been saved. This will save the program (for example, BadgerCare Plus and Medicaid) and service area (for example, Anesthesiologist) combinations that are selected from the drop-down menus. The next time the provider accesses the Online Handbook, they will be taken to their default preferences page. The provider can also click the Preferences Home link, which returns the provider to the saved area of the Online Handbook with their default preferences.

## 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.

### Add Backup Contact Information for Provider Administrator Accounts

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

Topic #4912

# Portal Clerk Administrators

A Portal administrator may choose to delegate some of the authority and responsibility for setting up and managing the users within their ForwardHealth Portal account. If so, the Portal administrator may establish a clerk administrator. An administrator or clerk administrator can create, modify, manage or remove clerks for a Portal account. When a clerk is created, the administrator or clerk administrator must grant permissions to the clerks to ensure they have the appropriate access to the functions they will perform. A clerk administrator can only grant permissions that they themselves have. For example, if an administrator gives a clerk administrator permission only for enrollment verification, then the clerk administrator can only establish clerks with enrollment verification permissions.

Even if a Portal administrator chooses to create a clerk administrator and delegate the ability to add, modify, and remove users from the same account, the Portal administrator is still responsible for ensuring the integrity and security of the Portal account.

Topic #4913

# Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their ForwardHealth Portal account. Clerks may be assigned one or many roles (i.e., claims, PA (prior authorization), member enrollment verification). Clerks do not have the ability to establish, modify, or remove other accounts.

Once a clerk account is set up, the clerk account does not have to be established again for a separate Portal account. Clerks can easily be assigned a role for different Portal accounts (i.e., different ForwardHealth enrollments). To perform work under a different Portal account for which they have been granted authorization, a clerk can use the "switch org" function and toggle between the Portal accounts to which they have access. Clerks may be granted different authorization in each Portal account (i.e., they may do member enrollment verification for one Portal account, and HealthCheck inquires for another).

Topic #4740

# Public Area of the Provider Portal

The public Provider area of the ForwardHealth Portal offers a variety of important business features and functions that will assist in daily business activities with ForwardHealth programs.

## Interactive Maximum Allowable Fee Schedule

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

## ForwardHealth Communications

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

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

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

## Trainings

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

## Contacting Provider Services

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

## Online Enrollment

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

## Other Resources Available on the Portal

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

- A "What's New?" section for providers that links to the latest information posted to the Provider area of the Portal
- Home page for the provider (Providers have administrative control over their Portal homepage and can grant other employees access to specified areas of the Portal, such as claims and PA.)
- Email subscription service for Updates (Providers can register for email subscription to receive notifications of new provider publications via email. Users are able to select, by program and service area, which publication notifications they would like to receive.)
- A forms library

Topic #4741

# Secure Area of the Provider Portal

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

## Claims and Adjustments Using the Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, and determine what claims are in "pay" status on the Portal. Providers can search for and view the status of all of their finalized claims, regardless of how they were submitted (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim via DDE (Direct Data Entry) through the secure Portal.

## Submitting PA and Amendment Requests Via the Portal

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

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

## Electronic Communications

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

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

## Enrollment Verification

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

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

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

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

## Other Business Enhancements Available on the Portal

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

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

Topic #4401

# System and Browser Requirements

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

| Recommended System Requirements | Recommended Browser Requirements |
|---|---|
| **Windows-Based Systems** | |
| Computer with at least a 500Mhz processor, 256 MB of RAM, and 100MB of free disk space | Chrome v. 73 or higher, Edge v. 19 or higher, Firefox v. 38 or higher |
| Windows XP or higher operating system | |
| **Apple-Based Systems** | |
| Computer running a PowerPC G4 or Intel processor, 512 MB of RAM, and | Chrome v. 73 or higher, Edge v. 19 or higher, |

| | |
|---|---|
| 150MB of free disk space | Safari v. 14 or higher, Firefox v. 38 or higher |
| Mac OS X 10.2 or higher operating system | |

Topic #4742

# Trading Partner Portal

The following information is available on the public Trading Partners area of the ForwardHealth Portal:

- Trading partner testing packets
- Trading partner profile submission
- PES (Provider Electronic Solutions) software and upgrade information
- EDI (Electronic Data Interchange) companion guides

In the secure Trading Partners area of the Portal, trading partners can exchange electronic transactions with ForwardHealth.

Trading partners using PES should be sure to enter the web logon and web password associated with the ForwardHealth Trading Partner ID that will be used on PES transactions. Prior to submitting transactions through PES, trading partners must also make sure their trading partner account is entered as the "Default Provider ID" on the Switch Organization page of the secure trading partner account on the Portal.

# Training Opportunities

Topic #12757

## Training Opportunities

The Provider Relations representatives conduct training sessions in a variety of formats on both program-specific and topic-specific subjects. There is no fee for attending/accessing these training sessions.

### On-Site Sessions

On-site training sessions are offered at various locations (e.g., hotel conference rooms, provider facilities) throughout the state. These training sessions include general all-provider sessions, service-specific and/or topic-specific sessions, and program-specific (such as WCDP (Wisconsin Chronic Disease Program) or the WWWP (Wisconsin Well Woman Program)) sessions.

Registration is required to attend on-site sessions. Online registration is available on the Trainings page of the Providers area of the Portal.

### Online (Real-Time, Web-Based) Sessions

Online (real-time, web-based) training sessions are available and are facilitated through HPE MyRoom. MyRoom sessions are offered on many of the same topics as on-site sessions, but online sessions offer the following advantages:

- Participants can attend training at their own computers without leaving the office.
- Sessions are interactive as participants can ask questions during the session.
- If requested or needed, a session can be quickly organized to cover a specific topic for a small group or office.

For some larger training topics (such as ForwardHealth Portal Fundamentals), the training may be divided into individual modules, with each module focused on a particular subject. This allows participants to customize their training experience.

Registration, including an e-mail address, is required to attend Virtual Room sessions, so important session information can be sent to participants prior to the start of the session. Online registration is available on the Trainings page of the Portal.

### Recorded Webcasts

Recorded Webcasts are available on a variety of topics, including some of the same topics as on-site and online sessions. Like Virtual Room sessions, some recorded Webcasts on larger training topics may be divided into individual Webcast modules, allowing participants to customize their training experience. Recorded Webcasts allow providers to view the training at their convenience on their own computers.

Registration is not required to view a recorded Webcast. Related training materials are available to download and print from the specific Webcast training session page on the Portal.

### Notification of Training Opportunities

In addition to information on the Trainings page of the Portal, upcoming training session information is distributed directly through messages to providers who have secure Portal accounts and to providers who have registered for the ForwardHealth e-mail subscription service.

To sign up for a secure Portal account, click the "Request Portal Access" link in the Quick Links box on the Provider page of the Portal. To sign up for e-mail subscription, click "Register for E-mail Subscription" in the Quick Links box on the Provider page of the Portal.

# Managed Care

# 9

**Archive Date:04/01/2024**

# Managed Care:Managed Care Information

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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/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) takes precedence over other ForwardHealth provider publications. Information contained in ForwardHealth publications is used by DHS to resolve disputes regarding covered benefits that cannot be handled internally by HMOs or PIHPs. If there is a conflict, the HMO or PIHP contract prevails. If the contract does not specifically address a situation, Wisconsin Administrative Code ultimately prevails. HMO and PIHP contracts are available on the Acute and Primary Managed Care page (click the HMO Providers link, then the Resources and Help tab) for HMOs and on the Children's Specialty Programs page of the ForwardHealth Portal (click the Children's Specialty Managed Care Plans link, then the Policy tab) for PIHPs.

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.

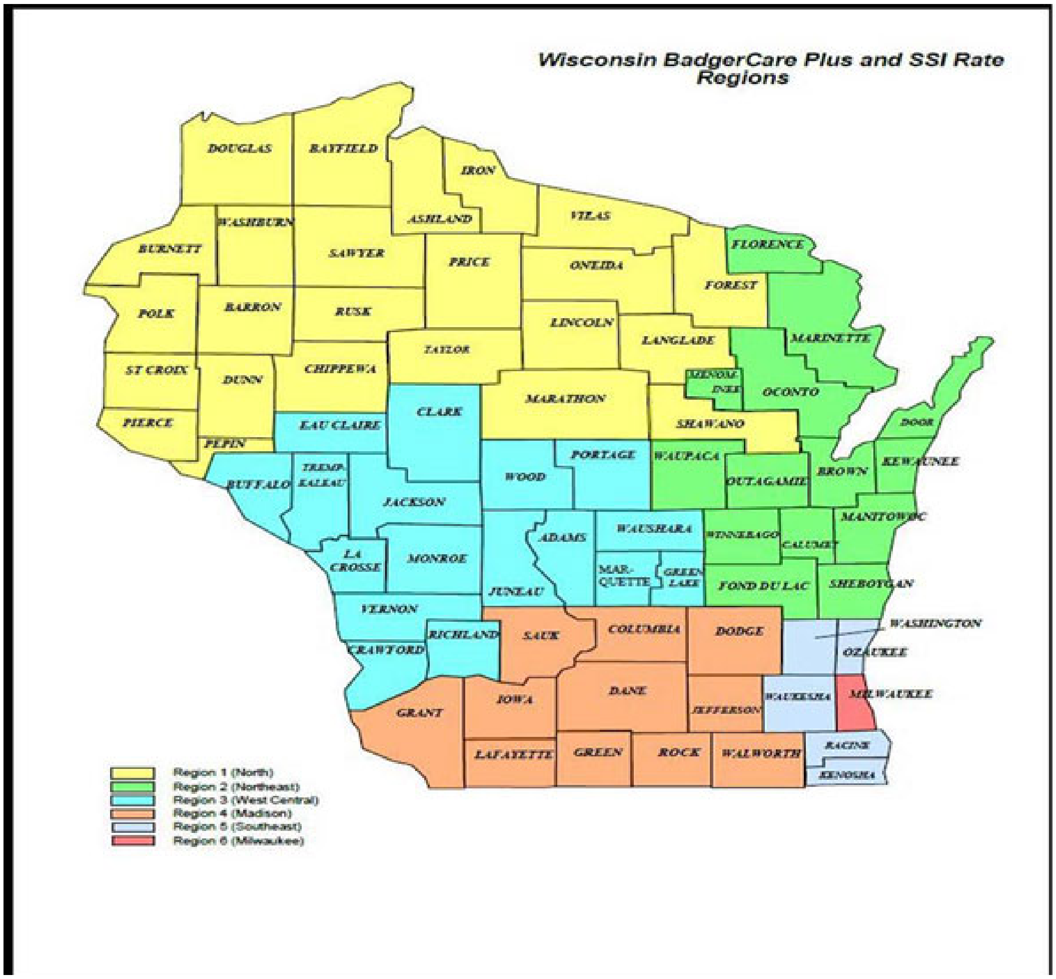
The SSI HMO care management teams will be responsible, when it is deemed appropriate, for notifying primary care providers of members' emergency room visits, hospital discharges, and other major medical events, as well as sharing patient-specific care management plans with appropriate providers to reduce 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
TAYLOR
ST CROIX
DUNN
CHIPPEWA
MENOMINEE
OCONTO
CLARK
MARATHON
EAU CLAIRE
PIERCE
PEPIN
SHAWANO
DOOR
WOOD
PORTAGE
WAUPACA
TREMPEALEAU
BUFFALO
OUTAGAMIE
BROWN
KEWAUNEE
JACKSON
ADAMS
WAUSHARA
WINNEBAGO
CALUMET
MANITOWOC
LA CROSSE
MONROE
MARQUETTE
GREEN LAKE
JUNEAU
FOND DU LAC
SHEBOYGAN
VERNON
RICHLAND
SAUK
COLUMBIA
DODGE
WASHINGTON
CRAWFORD
OZAUKEE
DANE
IOWA
GRANT
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)

## 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.

## 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.

# Covered and Noncovered Services

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Topic #16197

# Care4Kids Program Benefit Package

## Covered Services

Members enrolled in the Care4Kids program are eligible to receive all medically necessary services covered under Wisconsin Medicaid; however, Care4Kids will have the flexibility to provide services in a manner that best meets the unique needs of children in out-of-home care, including streamlining PA (prior authorization) requirements and offering select services in home settings. Members will also be allowed to go to any Medicaid-enrolled provider for emergency medical services or family planning services.

## Noncovered Services

The following services are not provided as covered benefits through the Care4Kids program, but can be reimbursed for eligible Medicaid members on a fee-for-service basis:

- Behavioral treatment
- Chiropractic services
- CRS (Community Recovery Services)
- CSP (Community Support Programs)
- CCS (Comprehensive Community Services)
- Crisis intervention services
- Directly observed therapy for individuals with tuberculosis
- MTM (Medication therapy management)
- NEMT (Non-emergency medical transportation) services
- Prescription and over-the-counter drugs and diabetic supplies dispensed by the pharmacy
- Physician-administered drugs and their administration, and the administration of Synagis
- SBS (School-based services)
- Targeted case management

Children's Hospital of Wisconsin will establish working relationships, defined in writing through a memorandum of understanding, with providers of the following services:

- CSP
- CCS
- Crisis intervention services
- SBS
- Targeted case management services

Providers of these services must coordinate with Care4Kids to help assure continuity of care, eliminate duplication, and reduce fragmentation of services.

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
- Physician-administered drugs

  *Note:*The Physician-Administered Drugs Carve-Out Procedure Codes table indicates the status of procedure codes considered under the physician-administered drugs carve-out policy.

- 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.

# 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.

## Claims

Topic #384

# Appeals to BadgerCare Plus/Medicaid SSI HMOs and Children's Specialty Managed Care PIHPs

BadgerCare Plus/Medicaid SSI HMO and Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) contracted and non-contracted providers are required to first file an appeal directly with the HMO/PIHP after the initial payment denial or reduction. Providers should refer to their signed contract with the HMO/PIHP or the HMO's/PIHP'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/PIHP may dictate the final decision. Filing a claim reconsideration is not the same as filing a formal appeal.

Appeal documents must reach the HMO/PIHP within the time frame established by the HMO/PIHP. Special care should be taken to ensure the documents reach the HMO/PIHP 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, secure Portal, fax, certified mail, or secure email).

The HMO/PIHP has 45 calendar days to respond in writing to a formal appeal. The HMO/PIHP decides whether or not to pay the claim and sends a letter stating this decision. If the HMO/PIHP does not respond in writing within 45 calendar days or the provider is dissatisfied with the HMO's/PIHP's response, the provider may submit an appeal to ForwardHealth through the Provider Appeals portal within 60 calendar days from the end of the 45 calendar day timeline or the date of the HMO/PIHP response.

Topic #385

# Appeals to ForwardHealth

ForwardHealth **will not review** appeals that were not first made to the BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan). If a provider sends an appeal directly to ForwardHealth without first filing it with the HMO/PIHP, the appeal will be returned to the provider., and the payment denial or reduction will be upheld.

The provider has 60 calendar days to file an appeal with ForwardHealth after the HMO/PIHP either does not respond in writing within 45 calendar days or if the provider is dissatisfied with the HMO/PIHP response.

Appeals will only be reviewed for enrollees who were eligible for and who were enrolled in an HMO/PIHP 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 HMO/PIHP will be notified by ForwardHealth of the final decision. If the decision is in the provider's favor, the HMO/PIHP 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 to ForwardHealth through the Provider Appeals portal.

## How to Begin Using the Provider Appeals Portal

Providers who contract with a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP and who need to appeal a claim decision will be required to register and set up a Provider Appeals portal account. Note: This portal account is separate from a provider's secure ForwardHealth Portal account.

To register for a Provider Appeals portal account, providers and HMOs/PIHPs can access the Provider Appeals portal. Providers are required to complete and submit the registration form, available by clicking either the HMO Registration or Provider Registration button (as applicable) on the Provider Appeals portal home page. Examples of information required to complete the registration process include the following:

- The provider's Medicaid ID or both their NPI (National Provider Identifier) and taxonomy code
- Provider ZIP+4 code
- Date of service for the appeal
- Contact information (name, email, phone number) for the person registering

Once ForwardHealth receives and processes the registration form, an account login ID and associated PIN (provider identification number) will be created. Providers will receive an email message with their Provider Appeals portal login ID and will receive their PIN information in a mailed letter.

Note: Third party administrators and out-of-state providers must call the EDI (Electronic Data Interchange) Helpdesk at 866-417-4979 or send an email to vedswiedi@wisconsin.gov to begin registration.

More information on registering for and using the Provider Appeals portal and additional portal resources, including the Provider Appeals Portal User Guide, is available.

# Portal Functionality

Providers can use the ForwardHealth appeals process through the Provider Appeals portal after exhausting the HMO/PIHP payment dispute process. Providers are required to use the Provider Appeals portal to:

- Submit an appeal to ForwardHealth for a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP claim payment denial or reduced payment.
- Submit documentation.
- Check the status of an appeal.
- Respond to requests for additional information.
- View decision notices.

For assistance regarding submission of an appeal through the ForwardHealth Portal, providers can call the ForwardHealth Managed Care Unit at 800-760-0001, option 1.

# Required Documentation

When submitting an appeal to ForwardHealth through the Provider Appeals portal, the following documentation must be submitted/attached in required fields:

- The original claim submitted to the HMO/PIHP and all corrected claims submitted to the HMO/PIHP
- All of the HMO's/PIHP'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/PIHP
- The HMO's/PIHP's response to the appeal
- Relevant medical documentation for appeals regarding coding issues or emergency determination that supports the appeal (Providers should only submit relevant documentation that supports the appeal. Large medical records submitted with no indication of where supporting information is found will not be reviewed.)

- Any contract language that supports the provider's appeal with the exact language that supports overturning the payment denial indicated (Contract language submitted with no indication of where supporting information is found will not be reviewed, and the denial will be upheld.)
- 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.

## Appeal Decisions

A decision to uphold the HMO's/PIHP's original payment denial or to overturn the denial will be made based on the documentation submitted to ForwardHealth for review. Failure to submit the required documentation or submitting incomplete, insufficient, or illegible documentation may lead to the original denial being upheld. The decision to overturn an HMO's/PIHP's denial must be clearly supported by the documentation.

If the HMO/PIHP subsequently overturns their original denial and reprocesses and pays the claim for which an appeal has been submitted, providers must contact the ForwardHealth Managed Care Unit at 800-760-0001, option 1, and request that the appeal be withdrawn.

To check on the status of an appeal submitted to ForwardHealth, providers can:

- Access the Provider Appeals portal.
- Call the ForwardHealth Managed Care Unit at 800-760-0001, option 1.

Topic #386

# Claims Submission

BadgerCare Plus/Medicaid SSI HMOs and Children's Specialty Managed Care PIHPs (Prepaid Inpatient Health Plans) have requirements for timely filing of claims, and providers are required to follow the HMO/PIHP claims submission guidelines for each organization. Providers should contact the enrollee's HMO/PIHP for organization-specific submission deadlines.

Topic #387

# Extraordinary Claims

Extraordinary claims are BadgerCare Plus or Medicaid claims for a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) enrollee that have been denied by an HMO/PIHP but may be paid as fee-for-service claims.

The following are some examples of extraordinary claims situations:

- The enrollee was not enrolled in an HMO/PIHP at the time they were admitted to an inpatient hospital, but then they enrolled in an HMO/PIHP 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 HMO/PIHP 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 #21497

# HMO Data Submission for Non-Emergent Emergency Department Copay

The copay requirement applies to BadgerCare Plus childless adult members who are part of an HMO. HMOs must submit encounter data that indicates non-emergent ED visits subject to the $8 copay with 99281-99285 procedure code, modifier U1 (Non-emergent emergency room visit, eligible for $8 copay in accordance with 2017 Wisconsin Act 370) and revenue code range 450-459.

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/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan). Before submitting claims to HMOs/PIHPs, providers are required to submit claims to other health insurance sources. Providers should contact the enrollee's HMO/PIHP for more information about billing other health insurance sources.

Topic #389

# Provider Appeals

When a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) denies a provider's claim, the HMO/PIHP is required to send the provider a notice informing them of the right to file an appeal.

An HMO/PIHP network or non-network provider may file an appeal to the HMO/PIHP when:

- A claim submitted to the HMO/PIHP is denied payment.
- The full amount of a submitted claim is not paid.

Providers are required to file an appeal with the HMO/PIHP **before** filing an appeal with ForwardHealth.

# Promoting Interoperability Program

## 10

**Archive Date:04/01/2024**

# Promoting Interoperability Program:An Overview

Topic #12172

## Wisconsin Medicaid EHR Incentive Program

Refer to the Inpatient Hospital Online Handbook under the EHR (Electonic Health Record) Incentive Program section for complete information regarding the Wisconsin Medicaid EHR Incentive Program.