Claims

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Claims:Adjustment Requests

Topic #814

Allowed Claim

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

Topic #815

Denied Claim

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

Topic #512

Electronic

837 Transaction

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

Provider Electronic Solutions Software

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

Portal Claim Adjustments

Providers can submit claim adjustments via the Portal. Providers may use the search function to find the specific claim to adjust. Once the claim is found, the provider can alter it to reflect the desired change and resubmit it to ForwardHealth. Any claim ForwardHealth has paid within 365 days of the DOS (date of service) can be adjusted and resubmitted on the Portal, regardless of how the claim was originally submitted.

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

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

Topic #513

Follow-Up

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

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

Topic #515

Paper

Paper adjustment requests must be submitted using the Adjustment/Reconsideration Request (F-13046 (08/2015)) 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.

Overpayments

Topic #528

Adjustment Request vs. Cash Refund

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

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

Topic #532

Adjustment Requests

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

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

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

Electronic Adjustment Requests

Wisconsin Medicaid will deduct the overpayment when the electronic adjustment request is processed. Providers should use the companion guide for the appropriate 837 (837 Health Care Claim) transaction when submitting adjustment requests.

Paper Adjustment Requests

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

- Submit an Adjustment/Reconsideration Request (F-13046 (08/2015)) 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 #533

Cash Refunds

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

ForwardHealth
Financial Services Cash Unit
313 Blettner Blvd
Madison WI 53784

Topic #531

ForwardHealth-Initiated Adjustments

ForwardHealth may initiate an adjustment when a retroactive rate increase occurs or when an improper or excess payment has been made. ForwardHealth has the right to pursue overpayments resulting from computer or clerical errors that occurred during claims processing.

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

Topic #530

Requirements

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

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

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

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

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

Topic #8417

Voiding Claims

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

Responses

Topic #540

An Overview of the Remittance Advice

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

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

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

Topic #5091

National Provider Identifier on the Remittance Advice

Health care providers who have a single NPI (National Provider Identifier) that is used for multiple enrollments will receive an RA for each enrollment with the same NPI reported on each of the RAs. For instance, if a hospital has obtained a single NPI and the hospital has a clinic, a lab, and a pharmacy that are all enrolled in Wisconsin Medicaid, the clinic, the lab, and the pharmacy will submit separate claims that indicate the same NPI as the hospital. Separate RAs will be generated for the hospital, the clinic, the lab, and the pharmacy.

Topic #4818

Calculating Totals on the Remittance Advice for Adjusted and Paid Claims

The total amounts for all adjusted or paid claims reported on the RA (Remittance Advice) appear at the end of the adjusted claims and paid claims sections. ForwardHealth calculates the total for each section by adding the net amounts for all claims listed in that section. Cutback amounts are subtracted from the allowed amount to reach the total reimbursement for the claims.

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

Topic #534

Claim Number

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

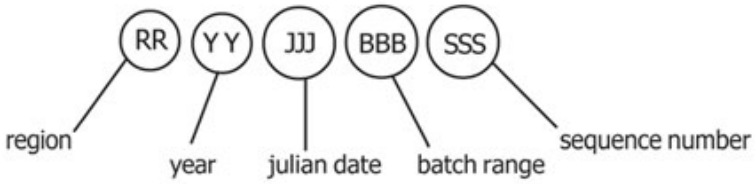
control number)). However, denied real-time compound and noncompound claims are not assigned an ICN, but receive an authorization number. Authorization numbers are not reported to the RA (Remittance Advice) or 835 (835 Health Care Claim Payment/Advice).

Interpreting Claim Numbers

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

Interpreting Claim Numbers

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



Type of Number and Description	Applicable Numbers and Description
Region — Two digits indicate the region. The region indicates how ForwardHealth received the claim or adjustment request.	10 — Paper Claims with No Attachments 11 — Paper Claims with Attachments 20 — Electronic Claims with No Attachments 21 — Electronic Claims with Attachments 22 — Internet Claims with No Attachments 23 — Internet Claims with Attachments 25 — Point-of-Service Claims 26 — Point-of-Service Claims with Attachments 40 — Claims Converted from Former Processing System 45 — Adjustments Converted from Former Processing System 50–59 — Adjustments 80 — Claim Resubmissions 90–91 — Claims Requiring Special Handling
Year — Two digits indicate the year ForwardHealth received the claim or adjustment request.	For example, the year 2008 would appear as 08.
Julian date — Three digits indicate the day of the year, by Julian date, that ForwardHealth received the claim or adjustment request.	For example, February 3 would appear as 034.
Batch range — Three digits indicate the batch range assigned to the claim.	The batch range is used internally by ForwardHealth.
Sequence number — Three digits indicate the sequence number assigned within the batch range.	The sequence number is used internally by ForwardHealth.

Topic #535

Claim Status

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

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

Topic #644

ClaimCheck Review

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

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

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

Areas Monitored by ClaimCheck

ForwardHealth uses ClaimCheck software to monitor the following situations:

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

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

Unbundled Procedures

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

If certain procedure codes are submitted, ClaimCheck rebundles them into the single most appropriate procedure code. For example, if a provider submits a claim with procedure codes 12035 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities [excluding hands and feet]; 12.6 cm to 20.0 cm) and 12036 (Repair, intermediate, wounds of scalp, axillae, trunk

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

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

Incidental/Integral Procedures

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

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

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

Mutually Exclusive Procedures

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

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

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

Medical Visit Billing Errors

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

Medical visit edits monitor services included in CPT (Current Procedural Terminology) procedure ranges 92002–92019, 99024 (postoperative follow-up), 99026–99058 (special services), 99202–99456 and HCPCS (Healthcare Common Procedure Coding System) procedure code G2212 (E&M codes), and HCPCS procedure codes S0620, S0621 (routine ophthalmological examinations).

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

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

Preoperative and Postoperative Billing Errors

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

For example, if a provider submits procedure code 99212 (Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making) with a DOS of 11/02/08 and procedure 27750 (Closed treatment of tibial shaft fracture [with or without fibular fracture]; without manipulation) with a DOS of 11/03/08, ClaimCheck will deny procedure code 99212 as a preoperative visit because it is submitted with a DOS one day prior to the DOS for procedure code 27750.

Medically Obsolete Procedures

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

Assistant Surgeon Billing Errors

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

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

Topic #22277

Claims Denial Adjustment/Review Request

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

- Review ForwardHealth remittance information for the specific reason for the denial.
- Review the claim submitted to ensure all information is accurate and complete.
- Consult recent CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) publications to make sure proper coding instructions were followed.
- Consult recent ForwardHealth publications to make sure current policy and billing instructions were followed.
- Call Provider Services for further information or explanation.
- Review the ForwardHealth Adjustment/Reconsideration Request process and submit a request if appropriate.

If a provider disagrees with a claim determination, the provider may take one of two actions.

- If the claim is denied, the provider may resubmit the claim with supporting documentation to Provider Services Written Correspondence using the Written Correspondence (F-01170 (07/2012)) form with the "other (briefly explain the situation in question below)" box checked and the words "medical consultant review requested" written on the form.
- If the original claim is in an allowed status, the provider may submit an Adjustment/Reconsideration Request (F-13046 (08/2015)) form with supporting documentation and the "medical consultant review requested" box checked on the form to Provider Services Written Correspondence.

Topic #4746

Cutback Fields on the Remittance Advice for Adjusted and Paid Claims

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

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

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

Topic #537

Electronic Remittance Information

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

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

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

Text File

The TXT format file is generated by financial payer and listed by RA number and RA date on the secure provider Portal account under the "View Remittance Advices" menu. RAs from the last 121 days are available in the TXT format. When a user clicks on an RA, a pop-up window displays asking if the user would like to "Open" or "Save" the file. If "Open" is chosen, the document opens based on the user's application associated with opening text documents. If "Save" is chosen, the "Save As" window will open. The user can then browse to a location on their computer or network to save the document.

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

Comma-Separated Values Downloadable File

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

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

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

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

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

835

Electronic remittance information may be obtained using the 835 (835 Health Care Claim Payment/Advice) transaction. It provides useful information regarding the processing of claims and adjustment requests, which includes the status or action taken on a claim, claim detail, adjustment, or adjustment detail for all claims and adjustments processed that week, regardless of whether they are reimbursed or denied. However, a real-time compound or noncompound claim will not appear on remittance information if the claim is denied by ForwardHealth. ForwardHealth releases payment information to the 835 no sooner than on the first state business day following the financial cycle.

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. The PES (Provider Electronic Solutions) software allows providers to submit electronic claims and claim reversals, and to download the 835 transaction. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Topic #4822

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

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

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

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

TEXT File

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

CSV File

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

Topic #13437

ForwardHealth-Initiated Claim Adjustments

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

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

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

Topic #4820

Identifying the Claims Reported on the Remittance Advice

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

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

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

Topic #11537

National Correct Coding Initiative

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

reimbursement.

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

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

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

Medically Unlikely Detail Edits

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

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

Procedure-to-Procedure Detail Edits

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

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

Quarterly Code List Updates

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

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

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

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

- Call Provider Services for further information or explanation.

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

- Complete the Adjustment/Reconsideration Request (F-13046 (08/2015)) 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 hosptial providers and hospice providers
Professional claims	Ambulance providers, ambulatory surgery centers, anesthesiologist assistants, audiologists, case management providers, certified registered nurse anesthetists, chiropractors, community care organizations, community support programs, crisis intervention providers, day treatment providers, family planning clinics, federally qualified health centers, HealthCheck providers, HealthCheck "Other Services" providers, hearing instrument specialists, home health agencies, independent labs, individual medical supply providers, medical equipment vendors, mental health/substance abuse clinics, nurses in independent practice, nurse practitioners, occupational therapists, opticians, optometrists, personal care agencies, physicial therapists, physician assistants, physician clinics, physicians, podiatrists, portable X-ray providers, prenatal care coordination providers, psychologists, rehabilitation agencies, respiratory therapists, rural health clinics, school-based services providers, specialized medical vehicle providers, speech and hearing clinics, speech-language pathologists, therapy groups

Topic #4418

Reading Non-Claims Processing Sections of the Remittance Advice

Address Page

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

Banner Messages

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

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

Explanation of Benefits Code Descriptions

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

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

Financial Transactions Page

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

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

Refunds are payments made to providers for overpayments.

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

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

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

Each new claim adjustment is assigned an identification number called the "Adjustment ICN (internal control number)." For other financial transactions, the adjustment ICN is determined by the following formula.

Type of Character and Description	Applicable Characters and Description
Transaction—The first character indicates the type of financial transaction that created the accounts receivable.	V—Capitation adjustment 1—OBRA Level 1 screening void request 2—OBRA Nurse Aide Training/Testing void request

Identifier—10 additional numbers are assigned to complete the Adjustment ICN.	The identifier is used internally by ForwardHealth.

Service Code Descriptions

The Service Code Descriptions section lists all the service codes (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 **entire amount** of the original paid claim and calculates a new payment amount for the claim adjustment. ForwardHealth does not recoup the **difference** — or pay the **difference** — between the original claim amount and the claim adjustment amount.

In the Claim Adjustments section, the original claim information in the claim header is surrounded by parentheses. Information about the claim adjustment appears directly below the original claim header information. Providers should check the Adjustment

EOB (Explanation of Benefits) code(s) for a summary of why the claim was adjusted; other header EOBs will provide additional information.

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

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

Below the claim header and the detail information will be located one of three possible responses with a corresponding dollar amount: "Additional Payment," "Overpayment To Be Withheld," or "Refund Amount Applied." The response indicated depends on the difference between the original claim amount and the claim adjustment amount.

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

If the difference is a negative dollar amount, indicating that the provider owes ForwardHealth additional monies, then the amount appears in the "Overpayment To Be Withheld" line. ForwardHealth automatically withholds this amount from payments made to the provider during the same financial cycle or during subsequent financial cycles, if necessary. This amount also appears in the Financial Transactions section as an outstanding balance under "Accounts Receivable."

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

Topic #4824

Reading the Claims Denied Section of the Remittance Advice

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

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

Sample Professional Services Claims Denied Section of the Remittance Advice

Remittance Advice — Professional Service Claims Denied Sample

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

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

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

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


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

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


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

Topic #4825

Reading the Claims Paid Section of the Remittance Advice

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

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

Sample Professional Services Claims Paid Section of the Remittance Advice

Remittance Advice — Professional Service Claims Paid Sample

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

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

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

MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MEMBER NO.: XXXXXXXXXXX
RRYYJJJBBBSSS  XXXXXXXXXXX  XXXXXXXXXXX  MMDDYY MMDDYY    9,999,999.99     9,999,999.99     999,999.99     9,999,999.99
                                                           9,999,999.99       999,999.99     999,999.99       999,999.99

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

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


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

Topic #4828

Remittance Advice Financial Cycles

Each financial payer (Medicaid, ADAP (Wisconsin AIDS Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program)) has separate financial cycles that occur on different days of the week. RAs (Remittance Advices) are generated and posted to secure provider Portal accounts after each financial cycle is completed. Therefore, RAs may be generated and posted to secure provider ForwardHealth Portal accounts from different payers on different days of the week.

Certain financial transactions may run on a daily basis, including non-claim related payouts and stop payment reissues. Providers may have access to the RAs generated and posted to secure provider Portal accounts for these financial transactions at any time during the week.

Topic #4827

Remittance Advice Generated by Payer and by Provider Enrollment

RAs (Remittance Advices) are generated and posted to secure provider Portal accounts from one or more of the following ForwardHealth financial payers:

- Wisconsin Medicaid (Wisconsin Medicaid is the financial payer for the Medicaid, BadgerCare Plus, and SeniorCare

programs)
- ADAP (Wisconsin AIDS Drug Assistance Program)
- WCDP (Wisconsin Chronic Disease Program)
- WWWP (Wisconsin Well Woman Program)

A separate Portal account is required for each financial payer.

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

The RA is generated per provider enrollment. Providers who have a single NPI (National Provider Identifier) that is used for multiple enrollments should be aware that an RA will be generated for each enrollment, but the same NPI will be reported on each of the RAs.

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

Topic #6237

Reporting a Lost Check

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

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

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

ForwardHealth
Financial Services
313 Blettner Blvd
Madison WI 53784

Topic #5018

Searching for and Viewing All Claims on the Portal

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

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

- Go to the Portal.

- Log in to the secure Provider area of the Portal.
- The most recent claims processed by ForwardHealth will be viewable on the provider's home page or the provider may select "claim search" and enter the applicable information to search for additional claims.
- Select the claim the provider wants to view.

Topic #4829

Sections of the Remittance Advice

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

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

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

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

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

Remittance Advice Header Information

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

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

- The technical name of the RA section (e.g., CRA-TRAN-R), which is an internal ForwardHealth designation
- The RA number, which is a unique number assigned to each RA that is generated
- The name of the payer (Medicaid, ADAP (Wisconsin AIDS Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program))

- The "Pay to" address of the provider. The "Pay to" address is used for mailing purposes.

The following information is in the middle of the header:

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

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

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

Topic #544

Verifying Accuracy of Claims Processing

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

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

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

Responsibilities

Topic #516

Accuracy of Claims

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

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

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

Topic #547

Submission Deadline

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

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

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

Claims

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

Crossover Claims

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

Exceptions to the Submission Deadline

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

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

- Decision made by a court order, fair hearing, or the Wisconsin DHS (Department of Health Services)
- Denial due to discrepancy between the member's enrollment information in ForwardHealth interChange and the member's actual enrollment
- Reconsideration or recoupment
- Retroactive enrollment for persons on GR (General Relief)
- Medicare denial occurs after ForwardHealth's submission deadline
- Refund request from an other health insurance source
- Retroactive member enrollment

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

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

Topic #517

Usual and Customary Charges

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

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

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

For most services, ForwardHealth reimburses the lesser of the provider's usual and customary charge, plus a professional dispensing fee, if applicable, or the maximum allowable fee established.

Submission

Topic #17797

1500 Health Insurance Claim Form Completion Instructions

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

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

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

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

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

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

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Topic #542

Attached Documentation

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

Topic #6957

Copy Claims on the ForwardHealth Portal

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

Topic #5017

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

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

Topic #4997

Direct Data Entry of Professional and Institutional Claims on the Portal

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

- Professional claims
- Institutional claims

- Dental claims
- Compound drug claims
- Noncompound drug claims

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

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

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

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

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

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

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

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

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

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

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

Topic #344

Electronic Claim Submission

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

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

Topic #933

Electronic claims for PNCC (prenatal care coordination) services must be submitted using the 837P (837 Health Care Claim: Professional) transaction. Electronic claims for PNCC services submitted using any transaction other than the 837P will be denied.

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

Provider Electronic Solutions Software

The Wisconsin DMS (Division of Medicaid Services) offers electronic billing software at no cost to the provider. The PES (Provider Electronic Solutions) software allows providers to submit electronic claims using the 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 #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 #15417

Limitations

Each of the following PNCC (prenatal care coordination) services is limited to one claim per member, per provider for each calendar month:

- Health and nutrition education services provided individually
- Health and nutrition education services provided in a group setting
- Follow-up home visits
- Ongoing care coordination

Providers are required to bill all the services they provided in one month on the same claim; however, providers are required to indicate each DOS (date of service) on a separate detail.

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 #965

Ongoing Care Coordination

To be reimbursed for additional ongoing care coordination time which may have been omitted from the original claim, providers are required to submit an Adjustment/Reconsideration Request (F-13046 (08/2015)) form.

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

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (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 [X]

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

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

CITY: ANYTOWN STATE: WI

8. RESERVED FOR NUCC USE

CITY: STATE:

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

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [ ]

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

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

17a.

17b. NPI 0111111110

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

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

A. XXX.X B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

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

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

I.M. Provider MMDDCCYY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

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

a. 0222222220 b. ZZ123456789X

CARRIER

PATIENT AND INSURED INFORMATION

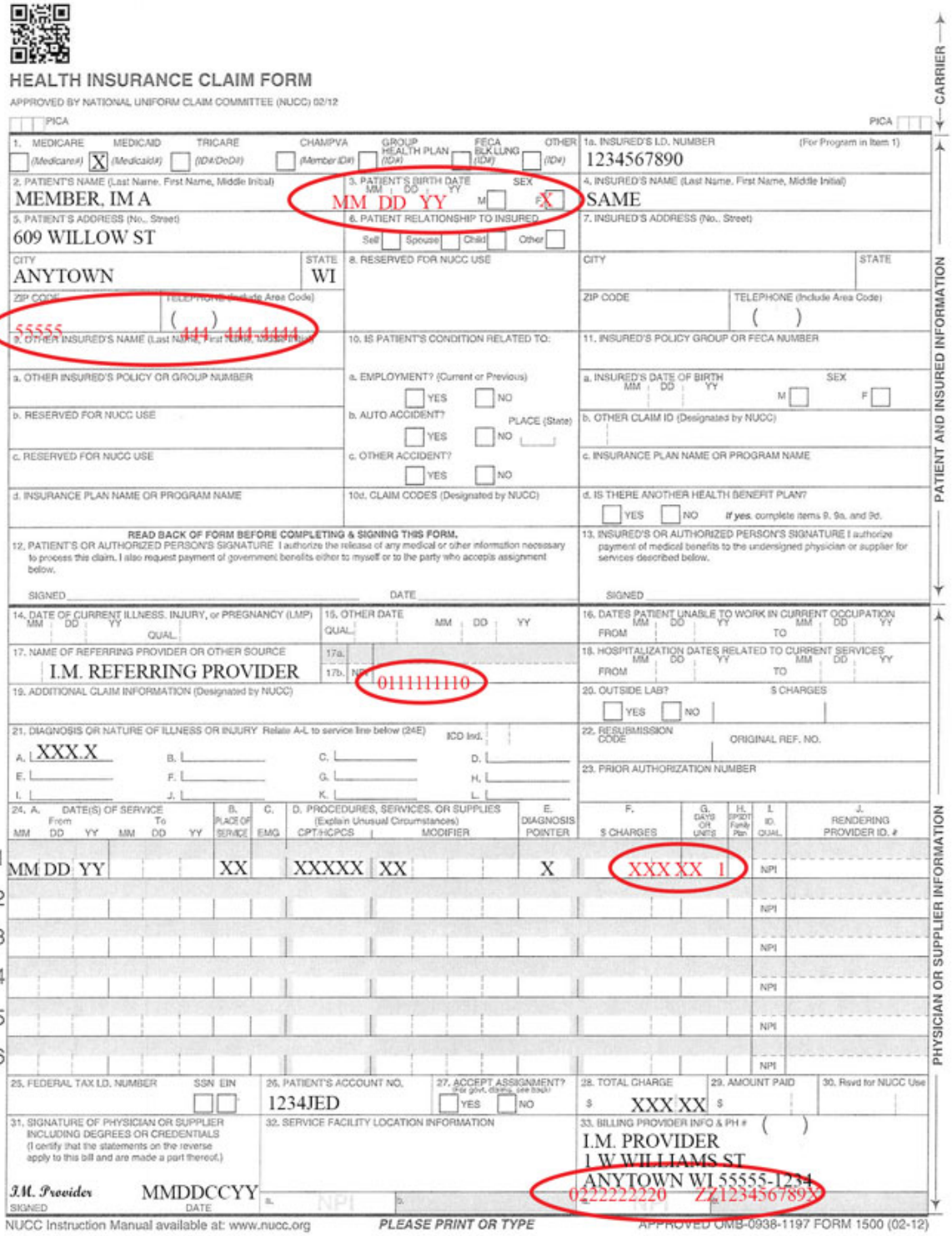
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Sample of an Incorrectly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

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

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

CITY: ANYTOWN | STATE: WI

8. RESERVED FOR NUCC USE

CITY | STATE

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

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

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

17a.

17b. NPI 0111111110

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

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

A. XXX.X B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. 1234JED

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

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

I.M. Provider MMDDCCYY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

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

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

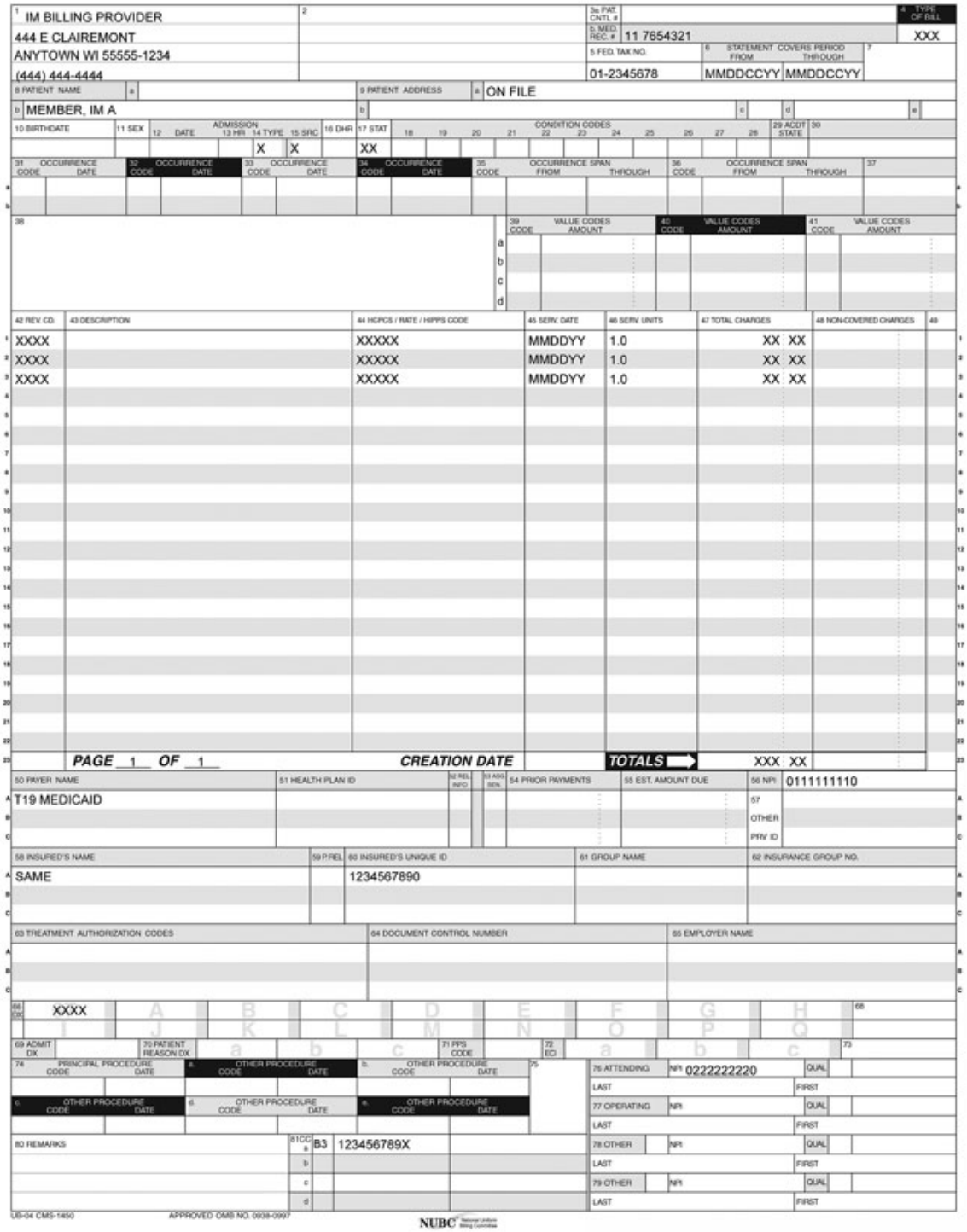
APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample of a Correctly Aligned UB-04 Claim Form



1 IM BILLING PROVIDER 444 E CLAIREMONT ANYTOWN WI 55555-1234 (444) 444-4444	3a PAT. CNTL # b. MED. REC. # 11 7654321 4 TYPE OF BILL XXX 5 FED. TAX NO. 01-2345678 6 STATEMENT COVERS PERIOD FROM MMDDCCYY THROUGH MMDDCCYY
8 PATIENT NAME b MEMBER, IM A	9 PATIENT ADDRESS a ON FILE
10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE X	15 SRC X	16 DHR	17 STAT XX	18–28 CONDITION CODES	29 ACDT STATE	30
31–34 OCCURRENCE CODE / DATE	35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	37
38	39–41 VALUE CODES / AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
XXXX		XXXXX	MMDDYY	1.0	XX XX		
XXXX		XXXXX	MMDDYY	1.0	XX XX		
XXXX		XXXXX	MMDDYY	1.0	XX XX		
	PAGE 1 OF 1	CREATION DATE		TOTALS	XXX XX		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 0111111110
T19 MEDICAID						57 OTHER PRV ID

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

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX	67 A–Q	68
XXXX		

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

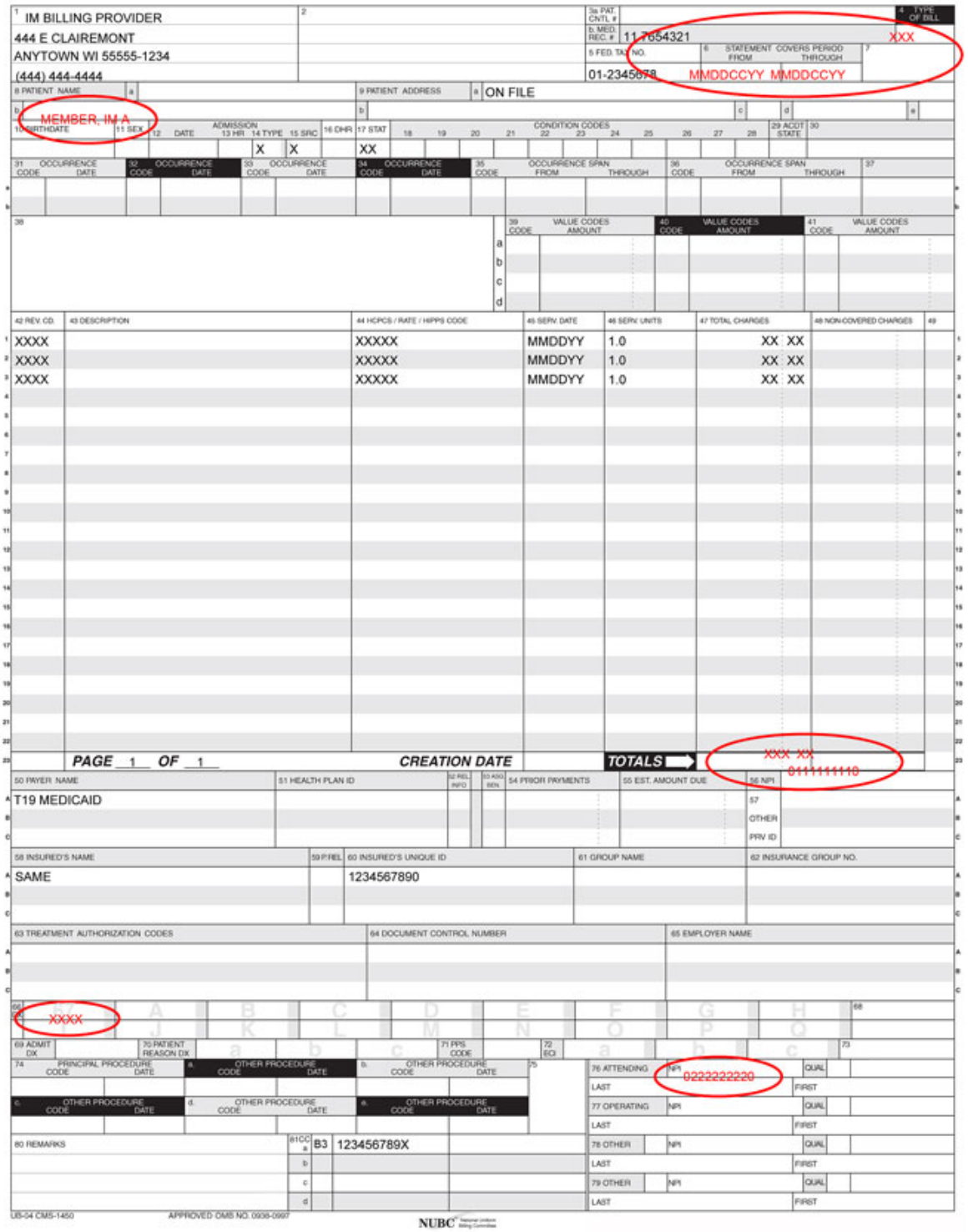
74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	

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

80 REMARKS	81CC		
	a	B3	123456789X
	b		
	c		
	d		

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

Sample of an Incorrectly Aligned UB-04 Claim Form



Topic #935

Paper Claim Submission

Paper claims for PNCC (prenatal care coordination) services must be submitted using the 1500 Health Insurance Claim Form ((02/12)). ForwardHealth denies claims for PNCC services submitted on any other claim form.

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

Obtaining the Claim Forms

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

Topic #936

Prenatal Care Coordination Pregnancy Questionnaire

The purpose of the Prenatal Care Coordination Pregnancy Questionnaire (F-01105 (02/2009)) form is to:

- Determine enrollment for the BadgerCare Plus PNCC (prenatal care coordination) benefit by identifying those risk factors that place a woman at high risk for a poor birth outcome.
- Make an initial assessment of the strengths and needs of the pregnant woman.

Providers are required to complete **every** section on the Pregnancy Questionnaire, using the Prenatal Care Coordination Pregnancy Questionnaire Completion Instructions (F-01105A (02/09)), unless the member objects to a particular section.

The Pregnancy Questionnaire must be:

- Reviewed and finalized in a face-to-face contact with the member
- Signed and dated by the agency staff member who completed the Pregnancy Questionnaire

A copy of the completed Pregnancy Questionnaire must be kept in the member's file and must also be shared with the member's HMO along with other information that could have a direct impact on the member's health or the health of the unborn baby (e.g., whether the member smokes or has a mental health diagnosis).

The PNCC provider and the HMO should work together to determine the appropriate level of information to be shared and the specifics of how and when information will be shared. These details should be outlined in the MOU (memorandum of understanding).

HIPAA (Health Insurance Portability and Accountability Act of 1996) and state confidentiality laws permit exchange of this information for treatment purposes and for health care operations; however, if a member requests that any or all of the Pregnancy Questionnaire or other information **not** be shared with the HMO, the PNCC provider should document the member's decision in the member's file and notify the HMO of that decision.

The person administering the Pregnancy Questionnaire must be an employee of the Medicaid-enrolled PNCC agency or an employee of an agency under contract to the PNCC agency. Qualified professionals are required to review and initial all Pregnancy Questionnaires completed by paraprofessional staff.

Wisconsin Medicaid reimburses for the administration of the Pregnancy Questionnaire regardless of the member's score. Members may be reassessed at any time, but providers need only readminister the entire Pregnancy Questionnaire if the member's situation changes significantly.

Using the Pregnancy Questionnaire to Determine Enrollment for Prenatal Care Coordination

Providers are required to use the Pregnancy Questionnaire to determine enrollment for the BadgerCare Plus PNCC benefit.

To determine enrollment, providers are required to do the following:

- Administer the Pregnancy Questionnaire in its entirety. The Pregnancy Questionnaire must be reviewed and finalized in a face-to-face contact with the pregnant woman.
- Circle the coded risk factors. The codes are listed along the right border of the form.
- Count the number of circled risk factors. A pregnant member is eligible to receive services if one of the following is true:
  - They are identified as having four or more risk factors.
  - They are less than 18 years old (regardless of the number of risk factors identified).
- Indicate eligibility for PNCC services by checking "Yes" or "No" in Section V of the Pregnancy Questionnaire. Write down the number of risk factors or the woman's age as appropriate.
- Sign and date the Pregnancy Questionnaire in Section V.

Note: A qualified professional is required to review, sign, and date all Pregnancy Questionnaires completed by paraprofessional staff.

Guidelines for Using the Pregnancy Questionnaire as an Initial Assessment Tool

Basic Screening Tool

The Pregnancy Questionnaire is a basic screening tool. All of the questions are integral to the initial assessment process.

Strengths and needs identified during the initial assessment must be addressed during the initial care plan development.

Strength-Based Approach

The administration of the Pregnancy Questionnaire in many cases is the initial interaction between the care coordinator and the pregnant woman and their family. This initial interaction increases the likelihood that the woman will enter into an ongoing relationship with the care coordinator to receive PNCC services. Forming the relationship with the pregnant woman and their family is a key first step. The care coordinator must be willing to enter the lives of families and base the interaction on the concerns, priorities, and goals identified by the member.

Ideally, the Pregnancy Questionnaire should occur within the context of a conversational-style interaction. A conversational style uses the woman's and/or their family's stories, personal observations, and survival, support, exception, possibility, and esteem questions to discover strengths. The completion of the Pregnancy Questionnaire needs to occur within the context and relevancy of what the woman and their family are seeking or needing for services that day as well as in the months to come.

Follow-up Assessment

Completing the Pregnancy Questionnaire should be viewed as the initial phase of an ongoing assessment process. In most cases, more information will be needed to develop a comprehensive care plan. Follow-up assessment questions can be woven into multiple interactions over time, whereby information is derived from conversations and observations. This activity is an important component of ongoing care coordination and monitoring services. While the Pregnancy Questionnaire is the beginning point of identifying the woman's needs, strengths, and goals, the ongoing assessment process is what ultimately drives the nature of services to be provided.

Sample follow-up assessment questions are included in the Prenatal Care Coordination Pregnancy Questionnaire Completion Instructions. Other commercial or self-designed assessment tools may also be used to complement the Pregnancy Questionnaire. Some comprehensive assessment tools are appropriate for all women receiving PNCC services, regardless of their response on

the initial assessment tool. For example, mental health experts recommend that all pregnant and postpartum women be screened for perinatal depression. The care coordinator may need to establish a relationship with the member before asking more in-depth, personal questions. However, if a safety or other critical concern is identified, the care coordinator should conduct the follow-up assessment immediately. It may be necessary to update the care plan based on the follow-up assessments.

Guidelines for Completing the Pregnancy Questionnaire

Complete every section of the Pregnancy Questionnaire unless the woman objects to a question(s). Background information is provided for select questions. The questions marked with an asterisk (*) identify possible risk factors. The rationale for identifying the situation as a risk factor is provided and referenced. Suggestions for additional assessment questions are provided when appropriate.

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 #4817

Submitting Paper Attachments with Electronic Claims

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

Paper attachments that go with electronic claim transactions must be submitted with the Claim Form Attachment Cover Page (F-13470 (10/2008)). Providers are required to indicate an ACN (attachment control number) for paper attachment(s) submitted with electronic claims. (The ACN is an alphanumeric entry between 2 and 80 digits assigned by the provider to identify the attachment.) The ACN must be indicated on the cover page so that ForwardHealth can match the paper attachment(s) to the correct electronic claim.

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

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

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

This does not apply to compound and noncompound claims.

Topic #11677

Uploading Claim Attachments Via the Portal

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

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

Claim Types

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

- Professional.
- Institutional.
- Dental.

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

Document Formats

Providers are able to upload documents in the following formats:

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

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

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

Uploading Claim Attachments

Claims Submitted by Direct Data Entry

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

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

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

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

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

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

Timely Filing Appeals Requests

Topic #549

Requirements

When a claim or adjustment request meets one of the exceptions to the submission deadline, the provider is required to mail ForwardHealth a Timely Filing Appeals Request (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: - The correct liability amount or LOC must be indicated on the Adjustment/Reconsideration Request (F-13046 (08/15)) form. - The most recent claim number (also known as the ICN (internal control number)) must be indicated on the Adjustment/Reconsideration Request form. This number may be the result of a ForwardHealth-initiated adjustment. - A copy of the Explanation of Medical Benefits form, if applicable.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Decision Made by a Court, Fair Hearing, or the Wisconsin Department of Health Services		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a decision is made by a court, fair hearing, or the Wisconsin DHS (Department of Health Services).	To receive consideration, the request must be submitted within 90 days from the date of the decision of the hearing. Include the following documentation as part of the request: - A complete copy of the decision notice received from the court, fair hearing, or DHS	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Denial Due to Discrepancy Between the Member's Enrollment Information in ForwardHealth interChange and the Member's Actual Enrollment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a claim is initially received by the deadline but is denied due to a discrepancy between the member's enrollment information in ForwardHealth interChange and the member's actual enrollment.	To receive consideration, the request must be submitted within 455 days from the DOS. Include the following documentation as part of the request: - A copy of remittance information showing the claim was submitted in a timely manner and denied with a qualifying enrollment-related explanation. - A photocopy of **one** of the following indicating enrollment on	ForwardHealth Good Faith/Timely Filing Ste 50 313 Blettner Blvd Madison WI

	the DOS: ¡ Temporary Identification Card for Express Enrollment in BadgerCare Plus ¡ Temporary Identification Card for Express Enrollment in Family Planning Only Services ¡ The response received through Wisconsin's EVS (Enrollment Verification System) from a commercial eligibility vendor ¡ The transaction log number received through WiCall ¡ The enrollment tracking number received through the ForwardHealth Portal	53784
ForwardHealth Reconsideration or Recoupment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when ForwardHealth reconsiders a previously processed claim. ForwardHealth will initiate an adjustment on a previously paid claim.	If a subsequent provider submission is required, the request must be submitted within 90 days from the date of the RA (Remittance Advice) message. Include the following documentation as part of the request: ¡ A copy of the RA message that shows the ForwardHealth-initiated adjustment ¡ A copy of the Explanation of Medical Benefits form, if applicable	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
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: ¡ A copy of the Explanation of Medical Benefits form, if applicable **And** ¡ "GR retroactive enrollment" indicated on the claim **Or** ¡ A copy of the letter received from the income maintenance or tribal agency	ForwardHealth GR Retro Eligibility Ste 50 313 Blettner Blvd Madison WI 53784
Medicare Denial Occurs After the Submission Deadline		

Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when claims submitted to Medicare (within 365 days of the DOS) are denied by Medicare after the 365-day submission deadline. A waiver of the submission deadline will not be granted when Medicare denies a claim for one of the following reasons: - The charges were previously submitted to Medicare. - The member name and identification number do not match. - The services were previously denied by Medicare. - The provider retroactively applied for Medicare enrollment and did not become enrolled.	To receive consideration, the request must be submitted within 90 days of the Medicare processing date. Include the following documentation as part of the request: - A copy of the Medicare remittance information - A copy of the Explanation of Medical Benefits form, if applicable	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Refund Request from an Other Health Insurance Source		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when an other health insurance source reviews a previously paid claim and determines that reimbursement was inappropriate.	To receive consideration, the request must be submitted within 90 days from the date of recoupment notification. Include the following documentation as part of the request: - A copy of the recoupment notice - An updated Explanation of Medical Benefits form, if applicable *Note:* When the reason for resubmitting is due to Medicare recoupment, ensure that the associated Medicare disclaimer code (i.e., M-7 or M-8) is included on the updated Explanation of Medical Benefits form.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Retroactive Member Enrollment into Medicaid		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a claim cannot be submitted within the	To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the	ForwardHealth Timely Filing

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

Coordination of Benefits

2

Archive Date:10/01/2021

Coordination of Benefits:Commercial Health Insurance

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 #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

Covered and Noncovered Services

3

Archive Date:10/01/2021

Covered and Noncovered Services:Codes

Topic #937

Diagnosis Codes on Claims for Prenatal Care Coordination Services

All codes indicated on submissions to ForwardHealth are required to be valid codes.

Claims submitted for PNCC (prenatal care coordination) services must include one of the following ICD (International Classification of Diseases) diagnosis codes as the primary diagnosis associated with the procedure:

- Z33.1 (Pregnant state, incidental)
- O09.90 (supervision of high risk pregnancy, unspecified, unspecified trimester)
- O09.91 (supervision of high risk pregnancy, unspecified, first trimester)
- O09.92 (supervision of high risk pregnancy, unspecified, second trimester)
- O09.93 (supervision of high risk pregnancy, unspecified, third trimester)

Providers are required to indicate the following diagnosis codes on claims for PNCC services:

- Z33.1 when submitting a claim on behalf of a member who does not meet the enrollment criteria (that is, those who are assessed but determined ineligible to receive services). Diagnosis code Z33.1 may only be used with procedure code H1000.
- O09.90–O09.93 when submitting a claim on behalf of a member who is identified as having four or more risk factors on the Prenatal Care Coordination Pregnancy Questionnaire (F-01105 (02/2009)) form or is under 18 years of age (that is, those who are determined eligible to receive services).
- O09.90–O09.93 when submitting claims with procedure codes H1000, H1002 and modifier U2, H1003, H1003 and modifier TT, H1004, and T1016 and modifier TH. Providers are required to indicate O09.90 (supervision of high risk pregnancy, unspecified, unspecified trimester), if the gestational age is unknown.

ForwardHealth will deny claims if providers indicate diagnosis codes other than the diagnosis codes listed above as the primary diagnosis when submitting claims for PNCC services. Providers may use additional ICD diagnosis codes in the secondary positions as appropriate.

Topic #938

Modifiers

Wisconsin Medicaid recognizes two locally defined modifiers (U1 and U2) and two nationally defined HCPCS (Healthcare Common Procedure Coding System) modifiers (TH and TT) for PNCC (prenatal care coordination) services. Modifier descriptions are as follows:

- Modifier U1 — For Wisconsin Medicaid providers, U1 in the PNCC service area is defined as "subsequent pregnancy." Modifier U1 must be indicated with all procedure codes when submitting claims for PNCC services within 185 days of a previous pregnancy.
- Modifier U2 — For Wisconsin Medicaid providers, U2 in the PNCC service area is defined as "initial care plan development." This modifier must be indicated with procedure code H1002 when billing for initial care plan development.
- Modifier TH — Nationally defined as "obstetrical treatment/services, prenatal or postpartum." This modifier is valid only

with procedure code T1016.
- Modifier TT — Nationally defined as an "individualized service provided to more than one patient in same setting." This modifier is valid only with procedure code H1003.

Modifier for Subsequent Pregnancy

In some circumstances, a confirmed subsequent pregnancy may require the provision of PNCC services within 185 days of the provision of services for an earlier pregnancy. Providers are required to indicate modifier U1 with a PNCC procedure code if the DOS (date of service) falls within 185 days of the DOS for the same procedure code submitted for an earlier pregnancy. For example, providers are required to use procedure code T1016 with both modifier TH and modifier U1 when submitting a claim for ongoing care coordination for a member's subsequent pregnancy if the DOS falls within 185 days from the date the same service was billed for a previous pregnancy.

Providers are required to indicate modifier U1 with all PNCC procedure codes for subsequent pregnancies within 185 days of previous pregnancies. When submitting claims for the second risk assessment, the modifier representing the risk assessment score must also be indicated.

ForwardHealth will deny claims for services provided within 185 days from the previous DOS if the PNCC procedure code (and the corresponding required modifier, if applicable) is not accompanied by modifier U1.

Topic #939

Place of Service Codes

POS (place of service) codes are required on claims and other forms submitted to Wisconsin Medicaid. Reimbursable PNCC (prenatal care coordination) services must be performed in an allowable POS.

POS Code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing
06	Indian Health Service Provider-Based
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
19	Off Campus — Outpatient Hospital
21	Inpatient Hospital
22	On Campus — Outpatient Hospital
23	Emergency Room — Hospital
31	Skilled Nursing Facility
32	Nursing Facility
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility

54	Intermediate Care Facility/Individuals with Intellectual Disabilities
71	State or Local Public Health Clinic
72	Rural Health Clinic
99	Other POS

Topic #940

Procedure Codes

All claims submitted to ForwardHealth must include allowable HCPCS (Healthcare Common Procedure Coding System) procedure codes for PNCC (prenatal care coordination) services. Claims or adjustment requests received without the appropriate HCPCS codes will be denied. The following are allowable HCPCS procedure codes for PNCC services.

Procedure Code	Procedure Code Description	Required Modifier and Description*
H1000	Prenatal care, at-risk assessment	
H1002	Prenatal care, at-risk enhanced service; care coordination	U2 Initial care plan development
H1003	Prenatal care, at-risk enhanced service; education	
H1003	Prenatal care, at-risk enhanced service; education	TT Individualized service provided to more than one patient in same setting
H1004	Prenatal care, at-risk enhanced service; follow-up home visit	
T1016	Case management, each 15 minutes	TH Obstetrical treatment services, prenatal or postpartum
Note: Prenatal care coordination services are limited to $896.33 per member, per pregnancy.		

* Modifier U1 (subsequent pregnancy) must be indicated with all procedure codes when submitting claims for PNCC services within 185 days of a previous pregnancy.

Requirements

The following requirements apply to HCPCS procedure codes used for PNCC services:

- When submitting claims for the initial assessment, indicate procedure code H1000.
- When submitting claims for development of an initial care plan, indicate procedure code H1002 and modifier U2.
- When submitting claims for health and nutrition education services provided individually, indicate procedure code H1003. When submitting claims for health and nutrition education services provided in a group setting, indicate procedure code H1003 and modifier TT.
- When submitting claims for assessment or care plan updates, indicate procedure code T1016 and modifier TH or, if provided in the home, procedure code H1004.
- When submitting claims for follow-up visits provided in the home, indicate procedure code H1004. The only valid POS (place of service) for H1004 is 12 (home). For all other ongoing care coordination, indicate procedure code T1016 and

modifier TH.

Topic #970

Rounding Guidelines

Providers are required to round time units using the following rounding guidelines when submitting claims for ongoing care coordination and monitoring using HCPCS (Healthcare Common Procedure Coding System) procedure code T1016.

Accumulated time	Unit(s) billed
1-5 minutes	.3
6-10 minutes	.7
11-15 minutes	1.0
16-20 minutes	1.3
21-25 minutes	1.7
26-30 minutes	2.0

Topic #14977

Unit of Service

A unit of service varies according to PNCC (prenatal care coordination) service.

For ongoing care coordination (procedure code T1016 and modifier "TH"), one unit of service equals 15 minutes. Providers are required to add up their time on a daily basis and round time units using the PNCC rounding guidelines when submitting claims for ongoing care coordination.

For all other PNCC procedure services, a quantity of one represents a complete service regardless of the amount of time spent on the service.

Topic #643

Unlisted Procedure Codes

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

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

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

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

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

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

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

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

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

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

Unlisted Codes That Do Not Require Prior Authorization

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

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

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

How to Submit Claims and Related Documentation

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

- If submitting on paper using the 1500 Health Insurance Claim Form ((02/12)), the provider may do either of the following:
  - Include supporting information/description in Item Number 19 of the claim form.
  - Include supporting documentation on a separate paper attachment. This option should be used if Item Number 19 on the 1500 Health Insurance Claim Form does not allow enough space for the description or when billing multiple unlisted procedure codes. Providers should indicate "See Attachment" in Item Number 19 of the claim form and send the supporting documentation along with the claim form.
- If submitting electronically using DDE (Direct Data Entry) on the Portal, PES (Provider Electronic Solutions) software, or

837 (837 Health Care Claim) electronic transactions, the provider may do one of the following:

- Include supporting documentation in the Notes field. The Notes field is limited to 80 characters.
- Indicate that supporting documentation will be submitted separately on paper. This option should be used if the Notes field does not allow enough space for the description or when billing multiple unlisted procedure codes. Providers should indicate "See Attachment" in the Notes field of the electronic transaction and submit the supporting documentation on paper.
- Upload claim attachments via the secure Provider area of the Portal.

Topic #830

Valid Codes Required on Claims

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

Code Validity

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

Code Specificity for Diagnosis

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

Covered Services and Requirements

Topic #941

A Comprehensive Overview

PNCC (prenatal care coordination) services help a member and, when appropriate, the member's family, gain access to medical, social, educational, and other services related to the member's pregnancy. Wisconsin Medicaid PNCC services are available to Medicaid-eligible pregnant women with a high risk for adverse pregnancy outcomes during pregnancy through the first 60 days following delivery.

PNCC services include all of the following:

- Outreach
- Initial Assessment
- Care plan development
- Ongoing care coordination and monitoring
- Health education and nutrition counseling services (for members with an identified need)

Providers should be prepared to offer all five components of the PNCC benefit — not just the initial assessment — to eligible members.

Providers are encouraged to use the Guidelines and Performance Measurements for PNCC to help ensure that quality services are provided and activities are directed toward the program's objectives and goal.

Wisconsin Medicaid also uses the guidelines to monitor the administration of the benefit.

A woman at high risk for an adverse pregnancy outcome requires additional prenatal care services and follow-up because of medical or nonmedical factors that significantly increase the probability of having preterm birth, a low-birth-weight baby, or other negative birth outcome. A preterm birth is defined as a birth before the gestational age of 37 weeks; a low birth weight is defined as a birth weight of less than 2500 grams (5.5 pounds).

Prenatal Care Coordination Goal

The goal of the PNCC benefit is to improve birth outcomes among women who are deemed at high risk for poor birth outcomes. The main objectives for obtaining this goal include ensuring that women at high risk:

- Are identified as early as possible in their pregnancy
- Receive individual psychosocial support and services
- Receive early and continuous prenatal care services
- Receive necessary health and nutrition education
- Are referred to available community services, as appropriate
- Receive assistance in accessing and obtaining needed health and social services

PNCC services do not end with the completion of the initial assessment, unless the assessment determines the member does not need further assistance. To obtain the program's goal, it is critical that providers have the ability to offer all five components of the PNCC benefit, and not just the assessment, to eligible members.

The following terms are used to describe PNCC providers and staff:

- Care Coordination Provider — The entity that meets the requirements as a certified care coordination provider, is assigned a Medicaid billing provider number, and has legal liability for the provision of care coordination services.
- Care Coordinator — The individual who is providing care coordination services to members.

Topic #966

Concurrent Services

A member should not receive care coordination services from more than one provider. ForwardHealth does not deny claims for concurrent services (unless the DOS (date of service) is the same), but notifies both providers of the overlap. It is the providers' responsibility to eliminate the overlap by communicating with the member and with each other to determine which provider will continue to provide the services. The member must ultimately determine the provider of service.

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 #943

Guidelines and Performance Measurements

The Guidelines and Performance Measurements for PNCC (prenatal care coordination) provide detailed information about the benefit's operational standards and performance measurements. Wisconsin Medicaid uses the performance measurements to determine if providers are complying with the benefit guidelines. If a guideline is not met, providers are required to have written documentation that reasonable alternatives are in place.

Providers are encouraged to use the guidelines to help ensure that quality services are provided and activities are directed toward the program's objectives and goals. Wisconsin Medicaid also uses the guidelines to monitor the administration of the benefit.

Prenatal Care Coordination Administration

Providers should use the following guideline when providing PNCC services:

Prenatal Care Coordination Administration	
Guideline	**Performance Measurement**
The provider must complete the following:	
I.A. Develop a plan that addresses the hiring and ongoing support and training of staff who can provide quality services that are family-centered and culturally appropriate.	**I.A.** The provider's plan to hire, support, and train staff to provide services that are family-centered and culturally appropriate must be documented and available for review. Documentation of staff training includes the name of the employee, date of training, and the employee's signature.
I.B. Develop and implement an outreach plan to inform	**I.B.** The provider is required to have an outreach plan available

potentially eligible pregnant women about the availability of PNCC services. At a minimum, the plan must: - Identify the provider's target population (e.g., teens only, all eligible members in the county, members in specific ZIP codes). - Outline the strategies that will be used to inform eligible members, the local community, social service providers, schools, local health care providers, and other appropriate agencies and organizations about the availability of PNCC services. Outreach efforts could also include community presentations, informational brochures, posters, billboards, television ads, or newspaper articles.	for review. The plan also must be specific to the target population and address strategies to inform eligible pregnant women about PNCC services.
I.C. Establish written procedures to ensure that care coordinators include members, to the full extent of their ability, in all decisions regarding appropriate services and providers.	**I.C.** Written procedures that meet the stated guidelines are available for review.
I.D. Develop and implement internal policies and procedures for ensuring that quality services are provided in accordance with Medicaid rules. At a minimum, these policies and procedures address: - Patient confidentiality. These policies must include clear statements regarding the type of information that can be released, the time period for which the authorization is valid, and the agencies or individuals to whom the information can be released. - Accuracy, legibility, and completeness of records (for example, the accurate scoring of Prenatal Care Coordination Pregnancy Questionnaires (F-01105 (02/2009)), the legibility of care plans and other written information, and documentation of all contacts with, or on behalf of, a member). - Procedures to ensure that priorities established in individual care plans are addressed in a timely manner. - Procedures to ensure that members are offered services that are sufficient in intensity. The procedures must include well-defined criteria for increasing or decreasing the intensity of services.	**I.D.** Written policies and procedures that meet the stated guidelines are available for review. Documentation of all activities that meet the stated guidelines is also available for review. Provider records indicate paraprofessional supervision every 30 days, at a minimum.

◦ Procedures to ensure that timely and appropriate referrals are made and there is follow up on all referrals. Unless otherwise stated, follow up on referrals must be made within two weeks of the referral. ◦ Ongoing staff training and support, including adequate supervision and support of paraprofessionals. Provide face-to-face supervision of paraprofessionals every 30 days, at a minimum. ◦ Appropriate staff-to-client ratio. Ensure that care coordinators have an adequate amount of time to spend with each member. The number of clients per care coordinator will vary depending on the needs of the members on their caseload. ◦ The provision of services by culturally competent staff. ◦ The provision of services that are family centered. ◦ Procedures to ensure that staff are following the provider's policies and procedures for the provision of services. The policies and procedures must clearly identify: ◦ The staff responsible for oversight of the policies and procedures ◦ Steps for prioritizing, monitoring, and correcting problem areas	
I.E. Establish written procedures to ensure that a qualified professional reviews and signs all assessments completed by paraprofessional staff.	**I.E.** The provider has written procedures requiring the review by and signature of qualified professionals of all Pregnancy Questionnaires completed by paraprofessionals.
I.F. Develop a written plan for providing timely, non-disruptive translator services for members who are hearing impaired and for members who do not speak or understand English. If the provider does not have an interpreter on staff, the provider must maintain a current list of interpreters who are "on call" to provide interpreter services. Do not use family members as interpreters when administering Pregnancy Questionnaires or for the initial care plan development. Do not use children as interpreters.	**I.F.** The provider has a written plan that meets the stated guidelines available for review. If the interpreter is not a staff member, the provider has a current list of "on call" interpreters available for review.

I.G. Develop written procedures for scheduling members for the initial assessment, initial care plan development, ongoing care coordination and services, and health and nutrition education, if appropriate. The schedule should allow adequate time with each individual to address their problems, develop a plan of action, and provide adequate education. If possible, schedule the initial assessment within 10 working days after the request for a service by a pregnant woman or after receiving a referral. The procedures must also include guidelines for staff regarding the time frame within which the initial contact must be scheduled after the Pregnancy Questionnaire and care plan are completed.	**I.G.** Written procedures that clearly outline the provider's plans for scheduling the initial assessment, the initial care plan development, and ongoing care coordination and monitoring services must be available for review.
I.H. Develop written procedures for following up with members who fail to keep appointments (care coordination, social service, prenatal or other appointments). Include time frames within which the member must be contacted and the steps designed to help the member keep future appointments.	**I.H.** Written procedures that meet the stated guidelines are available for review.
I.I. Maintain a current list of appropriate community resources (for referral purposes). The list includes, but is not limited to, the following services and agencies: - Adoption - AIDS (Acquired Immune Deficiency Syndrome)/HIV (Human Immunodeficiency Virus) - Adult protective services - Alcohol, tobacco, and other drug abuse - Child welfare services - Children with special health care needs program - Day care centers - Domestic/family violence - Early childhood intervention programs (e.g., Head Start, Birth to 3 Program) - Education - Employment/job training - Family planning - Food pantries/other food services - Housing and shelters for the homeless - Legal assistance	**I.I.** A current list of appropriate community resources — including, but not limited to, the services and agencies stated in the guidelines — and addresses, telephone numbers, and any associated costs is on file.

◦ Social services (e.g., family/marriage counseling, family support services, clothing for newborns) ◦ Parenting education (including fathers) ◦ Perinatal loss/grief counseling ◦ Respite/family resource centers ◦ Transportation ◦ WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) programs The list(s) must include the description of services offered, name of agency, address, telephone number, contact person, and any costs associated with the services.	
I.J. Establish working relationships (for the purpose of referrals) with key community agencies, social services providers, HMOs, and Medicaid primary care providers. If possible, develop written agreements that address the specific procedures to be followed for making referrals and for obtaining information on the outcome of the referrals from these agencies and providers. Ensure that staff are aware of these agreements. Medicaid HMOs are required to sign an MOU (memorandum of understanding) with all PNCC providers in their service area.	**I.J.** The provider's file includes written agreements or documentation that show that the provider has made good faith efforts to develop effective working relationships with key health and social services providers. The provider has on file a current MOU with each HMO in the county.
I.K. Establish written procedures regarding the release of member-specific information. Members may sign a general release of information. However, providers must obtain specific approval to release sensitive information about the member.	**I.K.** The provider has written policies regarding the release of member-specific information. The policies specifically address the release of sensitive information.

Pregnancy Questionnaire Administration

The provider must administer the Medicaid-approved assessment tool (the Pregnancy Questionnaire) to determine eligibility for the benefit. The assessment tool is designed to identify the member's strengths and needs. In addition to the Pregnancy Questionnaire, the provider may use any commercial or self-designed form to conduct a more detailed assessment.

All members must have a completed copy of the Pregnancy Questionnaire in their file.

Note: The Pregnancy Questionnaire includes several questions to which the member may object. Prior to administering the Pregnancy Questionnaire, explain the assessment and care plan process, acknowledge the intrusiveness of some of the questions and explain why you need to ask the questions. If necessary, share your agency's confidentiality policies with the member, including who will have access to the information provided.

Pregnancy Questionnaire Administration	
Guideline	**Performance Measurement**

The provider must complete the following:	
II.A. Administer and score the Pregnancy Questionnaire in its entirety unless the member objects to a particular question or section, or the information is unavailable.	**II.A.** The member's file includes a completed and scored Pregnancy Questionnaire. If the Pregnancy Questionnaire is not completed in its entirety, there is documentation that explains why.
II.B. Review and finalize the Pregnancy Questionnaire in a face-to-face meeting with the member. The staff completing the Pregnancy Questionnaire must sign and date it. A qualified professional must review and sign all Pregnancy Questionnaires completed by paraprofessional staff.	**II.B.** The member's file includes documentation that the Pregnancy Questionnaire was reviewed and finalized in a face-to-face visit. The Pregnancy Questionnaire is signed and dated. The member's file also includes documentation that a qualified professional reviewed and signed all Pregnancy Questionnaires completed by paraprofessional staff.
II.C. Inform members who are identified as having four or more risk factors on the Pregnancy Questionnaire that they are eligible to receive PNCC services. If the member is not interested in receiving services, try to determine the reason. Give the member a written copy of the agency's address and telephone number and ask the member to call or stop by if they change their mind.	**II.C.** The member's file documents that the member was offered PNCC services. If the member is not interested in receiving services, the reason is documented. The file includes documentation that the member received a written copy of the provider's address and telephone number and was asked to call if they change their mind about receiving services.
II.D. Inform members who are identified as having fewer than four risk factors on the Pregnancy Questionnaire that they are not eligible to receive PNCC services. Based on the member's identified needs, refer them to other community resources as appropriate. Give the member a written copy of the agency's telephone number and ask them to call or stop by if they has a significant negative change in their family, medical, social, or economic status while they are still pregnant. Also, the provider may reassess the member if someone, such as a health care professional, a school, or a social worker, refers them back to the provider. The provider may use the same Pregnancy Questionnaire if the reassessment or update is within 12 months of the initial assessment. Changes to the Pregnancy Questionnaire must be clearly identified (e.g., use a different color of ink, cross out old response). Do not erase or totally obliterate the original response.	**II.D.** The member's file includes documentation that the member was referred to other community resources as appropriate. The file also documents that the member was asked to contact the provider if they have a significant negative change in their family, medical, social, or economic status while they are still pregnant. Changes to the Pregnancy Questionnaire are legible and clearly identified. The Pregnancy Questionnaire is signed and dated.

Re-sign and date the Pregnancy Questionnaire.	
II.E. Use a new Pregnancy Questionnaire for assessments administered after 12 months of the initial assessment.	**II.E.** The member's file includes a new Pregnancy Questionnaire if more than 12 months have elapsed since the initial assessment.

Care Plan Development

The Pregnancy Questionnaire must be completed prior to the development of the care plan. The provider is not required to use a specific care plan format. However, the care plan must be based on the results of the Pregnancy Questionnaire.

Care Plan Development	
Guideline	**Performance Measurement**
The provider must complete the following:	
III.A. Develop a written individualized care plan for each member identified as having four or more risk factors on the Pregnancy Questionnaire. Develop only one care plan for each member.	**III.A.** The member's file includes an individualized care plan if the member is identified as having four or more risk factors on the Pregnancy Questionnaire.
III.B. Include the member in the development and any subsequent revisions of the care plan. Include family members and other supportive persons as appropriate. The member and provider who developed the care plan must sign and date the plan.	**III.B.** The member's file includes documentation that the member and, when appropriate, the member's family and other supportive persons actively participated in the development of the care plan. The member and the provider have signed and dated the care plan.
III.C. Inform the member that the care plan can be changed at any time and as often as necessary. Provide the member with information on how to request changes to the care plan, including the name and telephone number of the person to contact to initiate the change.	**III.C.** The member's file includes documentation of the stated guideline.
III.D. Ensure that the care plan includes the following: - Identification and prioritization of all strengths and problems identified during the initial assessment, including those related to health and nutrition education - Identification and prioritization of all services to be arranged with the member, including the names of the service providers (including health care providers) - A description of the member's informal support system, including collaterals, and activities planned to strengthen it if necessary	**III.D.** The member's file includes a care plan that meets the stated guidelines.

◦ Appropriate referrals and planned follow up ◦ Expected outcome of each referral ◦ Progress or resolution of identified priorities ◦ Documentation of unmet needs and gaps in service ◦ Planned frequency, time, and place of contacts with the member ◦ Identification of individuals who participated in the care plan development ◦ The member's responsibility in the plan's implementation If there are other care coordinators involved with the member, the care plan must address any needed collaboration or coordination. This requirement applies whether or not Wisconsin Medicaid covers the other care coordinators' services. The member's preferences concerning which care coordinator should provide services must be considered when the care coordinators' roles overlap.	
III.E. At a minimum, review and update the member's care plan every 60 days or sooner if the member's needs change. If necessary, update the member's care plan during each visit. All updates to the care plan must be signed or initialed and dated by the provider and the member.	**III.E.** The member's file includes documentation that the care plan was updated at least every 60 days. All updates to the care plan are signed or initialed and dated by the provider and the member.
III.F Provide the member with the written name and telephone number of: ◦ The person who will provide the ongoing care coordination services. If necessary, introduce the member to the care coordinator if they are different from the person who administered the assessment and developed the care plan. ◦ The person to contact in urgent situations or as backup when the care coordinator is unavailable.	**III.F.** The member's file includes a copy of, or documentation stating that the provider gave to the member, written information identifying the name and telephone number of the care coordinator and of the person to contact as back-up.

Ongoing Prenatal Care Coordination and Monitoring

All members must have a care plan in their file that predates the delivery of ongoing PNCC services, except for in urgent situations. In such cases, the provider is required to document the urgent situation. The provider is required to document all member and collateral contacts. The documentation must include the following:

- The member's name

- The date of contact
- The full name and title of the person who made the contact
- A clear description of the reason for and nature of the contact
- The length of time of the contact (the number of minutes or the exact time [e.g., 9:15-10:05 a.m.])
- Where or how the contact was made

PNCC ongoing services must be based on the care plan.

PSYCHOSOCIAL SERVICES

The term "psychosocial" refers to those concerns about relationships and support systems, fears about personal safety or safety of other family members, fears about past or current physical or substance abuse, depression, or other mental health problems, worries about ability to meet basic needs for food and shelter, and significant stress about ability to cope with the current pregnancy.

Psychosocial services should be provided by professional staff who are qualified by education, training, and experience to provide the level of service the member needs.

Psychosocial services are provided to assist the pregnant woman in the following:

- Resolving relationship problems that may adversely affect their health and the outcome of their pregnancy
- Identifying and accessing other services that will support their efforts to maintain a healthy pregnancy, continue positive health behaviors, and provide a safe home for themselves and their children
- Understanding and dealing with the social-emotional aspects of pregnancy and parenting
- Evaluating behaviors that may interfere with having a healthy pregnancy and infant, such as substance abuse, poor nutrition, and high-risk sexual behavior

Ongoing Care Coordination and Monitoring	
Guideline	**Performance Measurement**
The provider must complete the following:	
IV.A On an ongoing basis, the provider must: - Determine which services identified in the care plan have been or are being delivered. - Determine if the services are adequate for the member's needs. - Provide supportive contact to ensure that the member is able to access services, is actually receiving services, or is engaging in activities specified in the care plan. - Monitor the member's satisfaction with the service. - Ask the member to evaluate the quality, relevance, and desirability of the services to which they have been referred. - Identify changes in the member's circumstances that would require an adjustment in the care plan.	**IV.A.** The member's file includes documentation that indicates the provider offered ongoing services as stated.
IV.B. Provide the member with information on community	**IV.B.** The member's file indicates that the provider made

resources and referrals to other agencies when appropriate. Whenever possible, provide written referrals. Written referrals must include: - The care coordinator's name, address, and telephone number - The member's name - The date that the referral is made - The name, address, and telephone number of the agency/provider to which the member is being referred - The reason for the referral	available information on community resources and provided referrals as appropriate. A copy of all written referrals is maintained (or noted, if verbal) in the member's file.
IV.C. When referring the member for services, the care coordinator must: - Ensure that the member understands the reason and need for the referral. - Inform the member of all available options for obtaining the needed service. - Explain any costs involved or limitation in the service. - Assist the member in learning how to access the service for which the referral was made, including the appropriate use of contact name, telephone number, and address. - Follow up with the service agency, including appropriate advocacy on behalf of the member to ensure that services are provided. Follow up on referrals within two weeks unless otherwise dictated by the urgency of the circumstance.	**IV.C.** The member's file includes copies of referrals, consent for release of information, and documentation of the coordinator's follow up on all referrals with the member and the service provider.
IV.D. Ensure that the intensity and frequency of contacts with the member corresponds to the level of need and/or risk identified by the Pregnancy Questionnaire. For example, schedule frequent face-to-face visits if the member is in crisis, if there is violence in the home, or if the member is a first-time parent with no support system. If necessary, call or visit the member daily or weekly. At a minimum, contacts or visits should occur no less than every 30 days. If possible, schedule more frequent visits during the	**IV.D.** The member's file includes documentation that contacts with the member correspond to the level of need/risk and includes the date, time, location, and length of member contact, progress and/or resolution of identified problems, and signature of the professional reviewer. The member's file includes documentation supporting contacts with the member that are less frequent than the stated guidelines.

early months of pregnancy.	
IV.E. Assist the member in accessing and appropriately using the health care delivery system. For example, ensure that the member: - Can identify their primary/obstetric care provider, clinic, and HMO - Has their health care providers' telephone numbers and addresses and knows where to find them - Knows the proper procedures for obtaining medical information or health care after hours - Understands how to obtain specialty care, for example, mental health/substance abuse (alcohol and other drug abuse) treatment - Knows when to use the hospital emergency room - Knows how to schedule, reschedule, and cancel appointments. Assist the member in obtaining information as appropriate.	**IV.E.** The member's file includes documentation of the member's knowledge, deficiencies, and information provided as stated in the guidelines.
IV.F. Refer the member for counseling and support in the grief process when there is an early pregnancy loss (before 20 weeks gestation).	**IV.F** The member's file includes documentation and follow up on the referral.
IV.G. If the member indicates a desire to have an elective abortion, refer them to an appropriate medical provider for counseling. Inform the member that Wisconsin Medicaid does not cover care coordination services following an elective abortion.	**IV.G.** The member's file includes documentation of the referral.
IV.H. Refer members with complex psychosocial needs to additional community or mental health services. If the member exhibits behavior that may be dangerous to herself or others, immediately refer them to their health care or mental health provider in the community. Ensure follow up within 24 hours.	**IV.H.** The member's file includes appropriate referrals and documentation of timely follow up on the referrals. Member's file also documents follow up within 24 hours, if appropriate.
IV.I. Reassess the member's psychosocial risk status at least once each trimester and update the care plan as necessary. The assessment should include the member's strengths, weaknesses, support system, environment, actual and potential stressors, attitude toward the pregnancy, and past experiences with	**IV.I.** The member's file includes documentation of a periodic assessment. The care plan is updated as necessary.

pregnancy.	

Nutrition Counseling

Wisconsin Medicaid covers nutrition counseling if the need is identified in the Pregnancy Questionnaire and it is included in the member's individualized care plan. Pregnant women with nutrition-related needs may require a more in-depth nutritional assessment, nutrition education, and counseling by a registered/certified dietician or other qualified professional.

Nutrition Counseling	
Guideline	**Performance Measurement**
The provider must complete the following:	

V.A. Assess the member's knowledge and understanding of basic nutrition and dietary practices and how these factors could affect the pregnancy outcome for both them and the fetus. If possible, conduct the assessment during the first visit. Ensure that the care plan addresses the member's specific education needs. Provide or refer the member for education on the following topics as needed:
 	
- Recommended weight gain and weight gain goals.
- Recommended dietary intake and meal patterns. Suggestions to improve intake of:
  - Calcium-rich foods
  - Iron-rich foods and foods that enhance iron absorption
  - Folate-rich foods
- Use of vitamin and mineral supplements and over-the-counter medicines
- Avoidance of self-imposed diets and food practices that can be harmful
- Dietary interventions for common problems of pregnancy:
  - Nausea and vomiting in early pregnancy
  - Heartburn
  - Constipation
- Promotion and support of breastfeeding
- Resources for food, food budgeting, preparation, and storage, including referral and follow up on WIC Program participation
- Safe water source: refer for testing if lead, nitrates, or fluoride level might be a problem, and refer for dietary
	V.A. The member's file includes documentation of the assessment. The member's care plan addresses the member's specific education needs. A check-off list is permissible.

fluoride supplements when necessary.	
V.B. Conduct periodic reassessments throughout the pregnancy. All assessments must be signed and dated.	**V.B.** The member's file includes documentation of periodic reassessments. The assessments are signed and dated.
V.C. Refer members with more intensive nutritional-related needs to a dietitian if necessary. Problems indicating a need for referral to a registered/certified dietitian include, but are not limited to, the following: - Pre-pregnancy weight less than 20 BMI (Body Mass Index) - Pre-pregnancy weight greater than 26.0 BMI - Inappropriate weight gain based on weight gain recommendations of the Institute of Medicine, 1990 - Anemia: hematocrit < 30.0%, or hemoglobin < 10.0 g/dL - Pregnant woman's own history of childhood lead poisoning or current blood lead level ≥ 10 ug/dL within the last 12 months - Previous obstetrical complications: anemia, pregnancy-induced hypertension, fetal loss, premature delivery, inadequate weight gain, low-birth-weight infant, small-for-gestational-age infant, high-birth-weight infant - Current medical/obstetrical complications: diabetes, hypertension, renal disease, liver disease, cancer, cardiopulmonary disease, PKU (phenylketonuria), thyroid disease, gastrointestinal disease (e.g., parasites, short gut), hyperemesis gravidarum, severe infection, anesthesia/surgery/trauma within six months - Psychological problems: current or past history of eating disorders, depression influencing appetite or eating, intellectual disability, mental illness - Dietary factors: inadequate diet, milk allergy, lactose intolerance, self-imposed dietary restrictions, inappropriate use of supplements and OTC (over-the-counter) medications, insufficient resources to obtain, store, and prepare food to achieve an adequate dietary intake - Age 17 years or less at time of conception - 16 months or less between end of last pregnancy and	**V.C.** The member's file includes documentation of the specific reasons for referral to a registered/certified dietitian. The file also includes documentation of timely follow up with the dietitian to ensure the member is receiving nutrition care.

conception. - Multiple gestation - Smokes or uses alcohol or illicit drugs - Breastfeeding another child during current pregnancy - Pica (eating nonfood substances).	
V.D. Ensure that printed booklets and handouts obtained for distribution to members are appropriate for member's reading level and culture.	**V.D.** The provider has printed nutritional material that is appropriate for its target population.

Basic Health Information and Health Education

Wisconsin Medicaid covers health education if the need for it is identified in the Pregnancy Questionnaire and it is included in the member's individualized care plan. Pregnant women identified with health education-related needs may require in-depth health education and counseling by a qualified professional.

Basic Health Information and Health Education	
Guideline	**Performance Measurement**
The provider must complete the following:	
VI.A. Assess the member's knowledge and understanding about their medical status and health practices and the impact on their pregnancy outcome. Reassess the member periodically and provide ongoing education if necessary.	**VI.A.** The member's file includes documentation of the assessment. A check-off list is permissible if it identifies specific educational areas of need. The member's file also includes documentation of periodic reassessments.
VI.B. Ensure the member's care plan includes the identified health education needs, strategies for addressing them, and reasonable goals.	**VI.B.** The member's care plan addresses identified needs, strategies for addressing them, and reasonable goals.

VI.C. Provide basic health information to the member. Ensure that the information is easy to understand, culturally appropriate, and shared in a non-threatening and non-judgmental manner. The intent of providing basic information about pregnancy is to help the woman positively adjust to their new condition. At this level, the emphasis is not on behavior or lifestyle change but information sharing. Basic health information about prenatal care and pregnancy could include the following topics:
 	
- Importance of continuous prenatal care
- Normal changes due to pregnancy as it relates to each trimester
  - Maternal anatomy and physiology
  - Fetal development
	VI.C. The member's file includes documentation of the information provided.

¡ Emotional issues l Self-help strategies for common discomforts related to pregnancy l Self-care during pregnancy l Pregnancy complications ¡ Symptoms and self-detection of preterm labor ¡ Bleeding, infections during pregnancy, rupture of the bag of waters ¡ Emergency arrangements l Understanding the dangers of OTC medicines, prescription drugs, tobacco, alcohol, illicit drug use, and environmental and occupational hazards as they relate to pregnancy l Preparation for labor, delivery, and postpartum discharge: ¡ Hospital arrangements ¡ Support person to participate during labor and delivery l Preparation for the baby l Infant care, including nutrition and breastfeeding l Family planning	
VI.D. Provide or refer members for in-depth health education services if necessary. Ensure that the educational interventions address those high-risk medical conditions and health behaviors that can be alleviated or improved through education. Include the following topics as appropriate: l Education/assistance to stop smoking ¡ Decrease smoking alternative ¡ Effects of smoking on mother and fetal development l Education/assistance to stop alcohol consumption ¡ Emphasize importance of no alcohol during pregnancy ¡ Effect of alcohol on fetal development l Education/assistance to stop use of illicit or street drugs ¡ Emphasize no safe limit ¡ Effects of drugs on fetal development	**VI.D.** The member's file must include documentation of the need for more in-depth education. The file must also describe the type of education provided and the member's progress in meeting established goals. The file includes documentation of follow up on referrals.

- Education/assistance to stop high-risk sex practices
- Education on the safe use of OTC/prescription drugs
- Education on environmental/occupational hazards related to pregnancy
  - Potential exposure to hazard in member's own environment
  - Effects on fetal growth and development
  - Efforts to minimize exposure
- Lifestyle management
  - Relaxation techniques
  - Building self-esteem
  - Learning coping strategies and decision-making skills
  - Communication skills with health care providers, family, peers, etc.
- Reproductive health
  - Human sexuality
  - Environmental/occupational hazards
- Anticipatory guidance on childbirth, health and child growth and development
 	
Refer the member for additional support or information as needed. Ensure timely follow up on all referrals.	

VI.E. Ensure that printed booklets and handouts obtained for distribution to members are appropriate for members' reading level and culture.	**VI.E.** The provider has printed material that is appropriate for its target population.

Postpartum Services

PNCC services continue during the postpartum period (the first 60 days following delivery).

Postpartum Services	
Guideline	**Performance Measurement**
During the postpartum period, providers should complete the following:	
VII.A. Make at least one face-to-face contact. If possible, make at least one home visit.	**VII.A.** The member's file includes documentation of the contact.
VII.B. Update the member's care plan within 30 days after delivery. Address any negative changes in the member's postpartum medical and/or psychosocial condition with the member.	**VII.B.** The member's file indicates any necessary updates and follow ups.
VII.C. Refer the member for counseling and support if they	**VII.C.** The member's file includes documentation of the referral

have a stillbirth. Ensure timely follow up on the referral.	and follow up.
VII.D. Refer the member to the Infant Death Center of Wisconsin if there is a sudden, unexpected infant death. Ensure timely follow up on the referral.	**VII.D.** The member's file includes documentation of the referral and follow up.
VII.E. Refer the member for additional support and assistance in learning how to care for their child if the child is identified as having a special health care need (e.g., spina bifida, cleft lip, cerebral palsy) or a medical risk condition (for example, low birth weight, prematurity). Ensure timely follow up.	**VII.E.** The member's file includes documentation of the identified problem, referrals, and follow up.
VII.F. Assess the member's knowledge and understanding of basic postpartum care. Provide information as necessary. At a minimum, include the following topics in the assessment: - Personal hygiene - Nutrition during breastfeeding, including influence of tobacco, alcohol, and other drugs - Postpartum nutrition if formula feeding - Guides to successful breastfeeding, breast care, and routine self-breast checks - Physical activity and exercise - Recognition of minor gynecologic problems - Family planning - Prevention of STDs (sexually transmitted diseases) - Continuity of basic primary and reproductive health care	**VII.F.** The member's file includes documentation of the assessment, information or referral provided, and any follow up.
VII.G. Assess the member's interpersonal relationship with the infant. The assessment could include the member's strengths, weaknesses, support system, social environment, stresses, attitude toward the infant, and past experiences with parenting. Refer the member as appropriate.	**VII.G.** The member's file includes documentation of the assessment, information or referral provided, and any follow up.
VII.H. Assess the member's knowledge and understanding regarding appropriate newborn care and feeding practices and how these factors affect growth and development. Provide information or refer the member to a qualified professional as appropriate. At a minimum, include the following topics in your assessment:	**VII.H.** The member's file includes documentation of the assessment, information or referral provided, and any follow up.

▪ Infant's hunger and fullness cues ▪ Infant nutrition and appropriate feeding practices ▪ Successful breastfeeding ▪ Food and/or formula preparation and storage ▪ Bathing, skin and cord care, and diaper rash prevention ▪ Normal growth and development ▪ Taking infant's temperature, treatment of nausea, vomiting, dehydration, and fever ▪ Infant nurturing and stimulation ▪ Effects of secondhand smoke on infant health and nutrition ▪ Injury prevention and safety, including car seats, falls, poisoning, choking, sleep positions ▪ Appropriate use of infant's primary health care provider versus the emergency room	
VII.I. Encourage the member to choose a primary health care provider for the baby. Assist them in obtaining information regarding appropriate providers. Refer them to their HMO if appropriate.	**VII.I.** The member's file includes documentation of the referral and follow up.
VII.J. Inform the mother about the importance of timely immunization and regular well-child checkups. Assist them with making initial appointments, if needed.	**VII.J.** The member's file includes documentation of information provided, referrals given, and follow up.
VII.K. Assess the member's knowledge of the steps involved in obtaining appropriate and reliable child care. Provide information or refer the member for assistance if deficiencies are found in the following areas: ▪ Knowledge regarding available resources for checking provider references ▪ Evaluating child care settings for safety ▪ Obtaining financial assistance for child care ▪ Appropriate monitoring of the child care provider ▪ Reporting suspected child abuse or neglect by the child care provider	**VII.K.** The member's file includes documentation of the assessment, information provided, referrals given, and follow up.
VII.L. Refer women who require services beyond the postpartum period to other community resources before discharge from the PNCC program.	**VII.L.** The member's file includes documentation of PNCC postpartum contacts, referrals, follow up, and discharge from the program. The member's file also indicates the date of

Follow up on any referrals prior to the 60th day after delivery. Document the last DOS (date of service) (the date the member is discharged).	delivery.

Topic #942

Health Education and Nutrition Counseling

BadgerCare Plus covers health education and nutrition counseling under the PNCC (prenatal care coordination) benefit if all of the following occur:

- The medical need for health and/or nutrition education is identified in the Prenatal Care Coordination Pregnancy Questionnaire (F-01105 (02/2009)) form. Providers should follow up with a more comprehensive assessment of the member's health education and nutrition needs and strengths. Providers may use any appropriate assessment tool to conduct the follow-up assessment.
- The member's written individual care plan includes strategies and goals aimed at ameliorating the identified risk factors.
- A qualified professional provides the health education and nutrition counseling. The qualified professional is required to have the expertise, through education or at least one year of work experience, to provide health education and nutrition counseling.
- Services are provided face-to-face. Services may be provided in an individual or group setting. However, providers are required to establish clear strategies and goals for each member and include them in the member's individualized care plan.

Health Education

Health education may include, but is not limited to, the following topics:

- Education and assistance to stop smoking
- Education and assistance to stop alcohol consumption
- Education and assistance to stop the use of illicit or street drugs
- Education and assistance to stop potentially dangerous sexual practices
- Education on environmental and occupational hazards related to pregnancy
- Lifestyle management consultation
- Reproductive health education
- Preparation for childbirth
- Preparation for the baby

Nutrition Counseling

Nutrition counseling may include, but is not limited to, the following topics:

- Weight and weight gain
- Medical conditions (e.g., anemia, gestational diabetes)
- Previous and current nutrition-related obstetrical complications
- Psychological factors affecting nutritional status (e.g., depression, anorexia)
- Dietary factors affecting nutritional status (e.g., the use of supplements, the lack of food resources)
- Reproductive history affecting nutritional status (e.g., short inter-pregnancy interval, high parity)
- Breastfeeding education, infant nutritional needs

Topic #953

Initial Assessment

Providers are required to administer an initial, comprehensive risk assessment to all members. The purpose of this assessment is to determine the needs and strengths of the members. The Wisconsin DHS (Department of Health Services)-approved tool for the initial assessment is the Prenatal Care Coordination Pregnancy Questionnaire (F-01105 (02/2009)) form.

BadgerCare Plus will reimburse only one comprehensive assessment per member, per pregnancy, per provider.

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 #954

Ongoing Care Coordination and Monitoring

Ongoing care coordination and monitoring activities must be based on the member's written care plan. Wisconsin Medicaid will not cover ongoing care coordination and monitoring services that are not based on the member's care plan.

Ongoing care coordination and monitoring is a covered PNCC (prenatal care coordination) service for members who are identified as having four or more risk factors on the Prenatal Care Coordination Pregnancy Questionnaire (F-01105 (02/2009)) form or are under 18 years of age. Except in urgent care situations, providers are required to complete the Pregnancy Questionnaire and a care plan for each member prior to providing ongoing care coordination and monitoring services. Providers may offer ongoing care coordination services on the same date they completed the Pregnancy Questionnaire and care plan.

Activities for Ongoing Care Coordination and Monitoring

Covered activities include the following:

- Member contacts
- Collateral contacts
- Information and referral
- Assessment and care plan updates
- Recordkeeping

Member Contacts

Member contacts may be face-to-face, by telephone, or in writing, as appropriate. Except for health education and nutrition counseling, Wisconsin Medicaid does not cover member contacts for the direct provision of services. The provision of many medical services are reimbursed under other Medicaid benefits.

Wisconsin Medicaid does not limit the number of contacts providers may have with a member. However, reimbursement for the benefit is limited to a maximum amount per pregnancy, per member, per provider.

Collateral Contacts

A collateral is anyone who has direct supportive contact with the member, such as a family member, friend, service provider, guardian, housemate, or school official. Since the purpose of contacts with a collateral is to mobilize services and support on behalf of the member, the provider is required to identify the role of the collateral in the member's care plan.

Collateral contacts also include time spent on client-specific meetings and formal case consultations with other professionals or supervisors. Do not include time spent discussing or meeting on non-client-specific issues or time spent on general program issues.

Wisconsin Medicaid will not reimburse collateral contacts if there is no member contact during the month for which the provider is billing.

Information and Referral

Information and referral means providing members with current information about available resources and programs to help members gain access to needed services. Providers may complete a Referral Form, which contains reasons for the referral and an authorization of the referral by the member. Providers are required to ensure follow up on all referrals within two weeks, unless otherwise stated. Information and referral are reimbursed under care coordination.

Wisconsin Medicaid does not cover care coordination services on behalf of family members who are not Medicaid eligible. However, providers may assist non-Medicaid-eligible family members in accessing services needed to best meet the eligible member's needs.

Assessment and Care Plan Updates

Providers may update the Pregnancy Questionnaire and care plan and administer other assessment tools when necessary. These activities are reimbursed as care coordination services.

Recordkeeping

Wisconsin Medicaid considers recordkeeping a reimbursable ongoing care coordination and monitoring activity. Reimbursable recordkeeping activities include time spent on the following:

- Documenting the pregnancy (e.g., obtaining a signed statement from a physician, physician's assistant, certified nurse midwife, nurse practitioner, family planning clinic, or EE (Express Enrollment) provider)
- Updating care plans
- Documenting member and collateral contacts
- Preparing and responding to correspondence to and for the member

- Documenting the member's activities in relation to the care plan
- Determining and documenting the pregnancy outcome, including the infant's birth weight and health status

Recordkeeping is reimbursed only if a member contact occurred during the month for which the provider is billing.

If a member or collateral contact occurs on the last day of the month, the provider may submit a claim to Wisconsin Medicaid for the documentation of the contact in the following month (e.g., if the contact occurred on June 30, the provider may bill for the contact with the July contacts). Wisconsin Medicaid will only allow this exception if the provider documents the contact no later than the next business day.

Transportation Resources for Members

Although Wisconsin Medicaid does not cover transportation services as part of the PNCC benefit, providers often assist members in making transportation arrangements.

NEMT (non-emergency medical transportation) services for most members are provided through MTM, Inc., (Medical Transportation Management, Inc.) the transportation management system contracted with the Wisconsin DHS (Department of Health Services). Refer to the NEMT Online Handbook for more information about transportation services.

All providers may be asked to verify that a Medicaid member received Medicaid-covered services at their site on a particular date.

Provision of Services in Urgent Situations

When ongoing care coordination services are provided in an urgent situation (e.g., the woman is pregnant and homeless or pregnant and without food), the provider is required to:

- Document the nature of the urgent situation.
- Complete the Pregnancy Questionnaire and care plan as soon as possible but no later than 30 days following the actions taken to alleviate the urgent situation.

Providers may offer ongoing care coordination services to members in urgent situations, but Wisconsin Medicaid will not reimburse for these services when they are provided to members who are identified as having fewer than four risk factors on the Pregnancy Questionnaire or are over 18 years of age.

Frequency of Ongoing Monitoring

As part of the care planning process, the provider is required to discuss and document the planned frequency of ongoing contacts and monitoring with the member (and the member's collaterals, if appropriate). At a minimum, contacts should occur every 30 days. If possible, providers should schedule more frequent visits during the early months of the pregnancy.

Reduction or Termination of Ongoing Care Coordination Services

If a provider needs to reduce or terminate care coordination services for any reason, the provider should notify the member in advance and document this in the member's record. A decision that services can be reduced or terminated should be mutually agreed upon by the provider and member. The member's file must include a statement, signed and dated by the member, indicating agreement with the decision to terminate services. Changes in the care plan should always be discussed with the member, guardian, or parent.

In circumstances when the provider is unable to obtain a signature from the member for the termination of services (for example, the member consistently misses meetings with the provider and does not follow through on referrals, but indicates she wants to continue receiving PNCC services), the member's file must include documentation of all attempts to contact the member through

telephone logs and returned or certified mail. The provider is encouraged to provide the member with the names and addresses of other PNCC providers.

If a provider terminates ongoing PNCC services for any reason, the member's case is closed. However, there is no limit to the number of times a provider may reopen a member's case. The provider is required to document in the member's record why the case has been closed and reopened.

Topic #956

Other Care Coordinators

When multiple family members have care coordinators (case managers), the care plan must identify the role of each care coordinator. Coordinators may not duplicate services. This requirement applies whether or not Wisconsin Medicaid covers the other care coordinator's services.

Topic #944

Postpartum Services

Postpartum PNCC (prenatal care coordination) services are covered up to 60 days following delivery. Postpartum PNCC services are covered only if the member received care coordination services prior to delivery. During the postpartum period, providers are required to:

- Make at least one face-to-face visit with the member.
- Encourage the member to choose a primary health care provider for the baby.
- Inform the member of the importance of immunizations and regular well-child checkups (HealthChecks) for the baby.

Providers may refer to the guidelines and performance measurements for additional information on services provided during the postpartum period.

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 #969

Prenatal Care Coordination and Child Care Coordination Services

The following requirements apply to PNCC (prenatal care coordination) and CCC (child care coordination) services:

- Providers may only submit one claim per member for each calendar month.
- Providers are required to indicate each DOS (date of service) on a separate detail when billing ongoing care coordination and monitoring services.
- PNCC and CCC services are available to members who are inpatients in hospital or nursing facilities if the services do not duplicate discharge planning services that the hospital or nursing facility is required to provide and the services are provided

during the 30 days prior to discharge.

Topic #14978

Quantity Limits for Prenatal Care Coordination Services

ForwardHealth has established quantity limits for the following PNCC (prenatal care coordination) services:

- Health and nutrition education services, whether provided individually (procedure code H1003) or in a group setting (procedure code H1003 and modifier TT), are limited to a quantity of 10 sessions per pregnancy.
- Follow-up home visits (procedure code H1004) are limited to a quantity of 10 per pregnancy.

Health and nutrition education services (procedure codes H1003, H1003 and modifier TT, and H1004) are limited to a quantity of one per DOS (date of service).

Note: Providers may not bill procedure codes H1003 and H1003 and modifier TT on the same DOS.

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 #972

Wisconsin Medicaid Managed Care

PNCC (prenatal care coordination) services are not covered by state-contracted Medicaid HMOs or special managed care programs (such as programs for people with disabilities). Therefore, providers should submit claims for PNCC services directly to ForwardHealth for members enrolled in these programs.

Topic #16917

Memorandums of Understanding

Medicaid-enrolled PNCC providers are required to have on file a signed copy of an MOU (memorandum of understanding) with a state-contracted BadgerCare Plus and Medicaid SSI HMO when the PNCC provider is located in the HMO's service area. This requirement applies regardless of whether or not the PNCC provider is providing services to members enrolled in the HMO.

The MOU provides a framework for effective communication between the PNCC provider and the HMO. It establishes a working relationship between both entities, outlines procedures for sharing information, and outlines respective roles and responsibilities.

Since an HMO has overall responsibility for its member's health care, the HMO needs to be aware of concerns that could have an impact on the member's pregnancy outcome.

All MOUs between PNCC providers and HMOs must include, at a minimum, all of the information below:

- Delineation of responsibilities of the PNCC provider, including the following:
  - Designating at least one individual to serve as a liaison between the PNCC provider and the HMO.
  - Sharing the liaison's name and contact information with the HMO.
  - Notifying the HMO when providing PNCC services to one of its members.
  - Contacting members referred by the HMO and working diligently to enroll them in PNCC within five days of receiving the referral. This includes the following:
    - Providing the HMO with the name and contact information of the member's designated care coordinator.
    - Notifying the HMO if the member is determined ineligible or if the member declines PNCC services.
  - Obtaining a written Release of Information from all members receiving PNCC services to support the sharing of information with obstetric care providers and other health care providers.
  - Sending the HMO a completed copy of the Prenatal Care Coordination Pregnancy Questionnaire (F-01105 (02/2009)) form within two business days of receiving the request.
  - Sharing other relevant information with the HMO to coordinate services and help ensure healthy birth outcomes.
  - Consulting with the designated HMO liaison, as needed, on member-specific issues.
  - Participating in meetings, as needed, to evaluate the effectiveness and efficiency of the MOU.

- Delineation of responsibilities of the HMO, including the following:
  - Designating at least one individual to serve as a liaison between the HMO and the PNCC provider. This individual will be the key point of contact for the PNCC provider.
  - Sharing the liaison's name and contact information with the PNCC provider.
  - Informing HMO members about the availability and benefits of PNCC services and sharing a listing of local PNCC providers, if necessary.
  - Informing appropriate network providers about the availability and benefits of PNCC services.
  - Encouraging obstetric care providers to establish MOUs with PNCC providers to delineate their working relationship.
  - Ensuring that appropriate staff and network providers understand when and how to refer women for PNCC services.
  - Facilitating communication between network providers and care coordinators, when necessary.
  - Participating in meetings, as needed, to evaluate the effectiveness and efficiency of the MOU.

- Identifying information and signatures of authorized representatives, including the following:
  - Information regarding the PNCC provider:
    - Name of PNCC agency
    - Name of authorized agency representative
    - Title of authorized agency representative
    - Signature of authorized agency representative
    - Date signed
    - Name and contact information for the designated PNCC coordination liaison, if known

- Information regarding the HMO:
  - Name of HMO
  - Name of authorized HMO representative
  - Title of authorized HMO representative
  - Signature of authorized HMO representative
  - Date signed
  - Name and contact information for the designated HMO liaison, if known

- Statement that MOU expires no later than three years from the latest date signed

Fee-for-service reimbursement for PNCC services may be recouped if providers do not have an updated MOU on file.

A sample MOU is provided for providers' reference.

The MOU must be reviewed every three years, at a minimum. Upon reviewing the MOU, the PNCC provider and HMO may choose to renew it as is or make changes, if necessary. If the PNCC provider and the HMO determine that no changes are necessary, they may simply re-sign and date the existing MOU.

If an MOU is not renewed, it will expire three years from the last signature date.

MEMORANDUM OF UNDERSTANDING (SAMPLE FORMAT) BETWEEN PRENATAL CARE COORDINATION PROVIDER AND HMO

INSTRUCTIONS

Prenatal Care Coordination (PNCC) services are paid fee-for-service by Wisconsin Medicaid and BadgerCare Plus for all members, including those enrolled in state-contracted HMOs. The PNCC provider may not determine the need for specific medical care, or make referrals directly to providers of medical care, for services covered under the HMO contract. The HMO is responsible for managing the member's overall care. The HMO and the PNCC provider agree to facilitate inter-agency communication and inform staff from both the HMO and the PNCC agency about the policies and procedures for this cooperation, coordination, and communication.

PURPOSE AND SCOPE

Wisconsin Medicaid and BadgerCare Plus require the establishment of a memorandum of understanding (MOU) between PNCC providers and HMOs. The MOU recognizes that the PNCC agency and the HMO have "clients-in-common" and agree to cooperate in removing access barriers, coordinating care, and providing culturally competent services. The MOU provides a framework for establishing a working relationship between both entities.

PERIOD OF AGREEMENT

This MOU becomes effective on the date that **both** the HMO and the PNCC provider have signed it. The MOU remains in effect for three years from the date of the last signature. At the end of the three-year term, the MOU must be renewed in order to remain in effect. If the MOU is not renewed, it will expire.

This MOU may be amended at any time by mutual agreement, with the changes noted in a signed and dated addendum to this document.

Use of this sample MOU is optional, but the information contained in Sections I through III of this sample MOU must be included in any MOU between PNCC providers and HMOs.

SECTION I — RESPONSIBILITIES OF PRENATAL CARE COORDINATION PROVIDER

Under this agreement, the PNCC provider will do the following:

1. Designate at least one individual to serve as a liaison between the PNCC provider and the HMO.
2. Share the liaison's name and contact information with the HMO.
3. Notify the HMO when providing PNCC services to one of its members. (*HMO enrollment information is included in the ForwardHealth Enrollment Verification System*).
4. Contact members referred by the HMO and work diligently to enroll them in PNCC within five days of receiving the referral. This includes the following activities:
   - Providing the HMO with the name and contact information of the member's designated care coordinator.
   - Notifying the HMO if the member is determined ineligible or if the member declines PNCC services.
5. Obtain a written Release of Information from all members receiving PNCC services to support the sharing of information with obstetric care providers and other health care providers.
6. Send the HMO a completed copy of the *Pregnancy Questionnaire* within two business days of receiving the request.
7. Share other relevant information with the HMO to coordinate services and help ensure healthy birth outcomes.
8. Consult with the designated HMO liaison, as needed, on member-specific issues.
9. Participate in meetings, as needed, to evaluate the effectiveness and efficiency of this MOU.

SECTION II — RESPONSIBILITIES OF HMO

Under this agreement, the HMO will do the following:

1. Designate at least one individual to serve as a liaison between the HMO and the PNCC provider. This individual will be the key point of contact for the PNCC provider.
2. Share the liaison's name and contact information with the PNCC provider.
3. Inform HMO members about the availability and benefits of PNCC services and share a listing of local PNCC providers, if necessary.
4. Inform appropriate network providers about the availability and benefits of PNCC services.
5. Encourage obstetric care providers to establish MOUs with PNCC providers to delineate their working relationship.
6. Ensure that appropriate staff and network providers understand when and how to refer women for PNCC services.
7. Facilitate communication between network providers and care coordinators, when necessary.
8. Participate in meetings, as needed, to evaluate the effectiveness and efficiency of this MOU.

Continued

SECTION III — SIGNATURES OF AUTHORIZED REPRESENTATIVES	
Name — PNCC Agency	Name — HMO
Name — Authorized Agency Representative (Print)	Name — Authorized HMO Representative (Print)
Title — Authorized Agency Representative	Title — Authorized HMO Representative
SIGNATURE — Authorized Agency Representative	**SIGNATURE** — Authorized HMO Representative
Date Signed*	Date Signed*

*This MOU expires no later than three years from the latest date signed.

Name and Contact Information (if known) — Designated PNCC Liaison	Name and Contact Information (if known) — Designated HMO Liaison

Mental Health and Substance Abuse Screening for Pregnant Women

Topic #4442

An Overview

Definition of the Benefit

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

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

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

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

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

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

Mental Health and Substance Abuse Screening

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

Mental health screening tools available to providers include the following:

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

Substance abuse screening tools available to providers include the following:

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

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

Preventive Mental Health Counseling and Substance Abuse Intervention

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

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

Examples of effective strategies for treatment include the following:

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

Topic #4446

Coverage Limitations

Mental Health and Substance Abuse Screening

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

Preventive Mental Health Counseling and Substance Abuse Intervention

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

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

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

Topic #4444

Documentation Requirements

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

Topic #4443

Eligible Providers

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

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

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

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

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

HealthCheck providers (not including Case Management Only agencies)	Allowed	Not allowed	Allowed

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

Topic #4445

Procedure Codes and Modifiers

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

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

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

Noncovered Services

Topic #68

Definition of Noncovered Services

A noncovered service is a service, item, or supply for which reimbursement is not available. Wis. Admin. Code § DHS 101.03 (103) and ch. 107 contain more information about noncovered services. In addition, Wis. Admin. Code § DHS 107.03 contains a general list of noncovered services.

Topic #104

Member Payment for Noncovered Services

A provider may collect payment from a member for noncovered services if certain conditions are met.

Providers may not collect payment from a member, or authorized person acting on behalf of the member, for certain noncovered services or activities provided in connection with covered services, including the following:

- Charges for missed appointments
- Charges for telephone calls
- Charges for time involved in completing necessary forms, claims, or reports
- Translation services

Missed Appointments

The federal CMS (Centers for Medicare and Medicaid Services) does not allow state Medicaid programs to permit providers to collect payment from a member, or authorized person acting on behalf of the member, for a missed appointment.

Avoiding Missed Appointments

ForwardHealth offers the following suggestions to help avoid missed appointments:

- Remind members of upcoming appointments (by telephone or postcard) prior to scheduled appointments.
- If a member needs assistance in obtaining transportation to a medical appointment, encourage the member to call MTM, Inc. (Medical Transportation Management, Inc.) for NEMT (non-emergency medical transportation). Most Medicaid and BadgerCare Plus members may receive NEMT services through MTM, Inc. if they have no other way to receive a ride. Refer to the NEMT service area for more information.
- If the appointment is made through the HealthCheck screening or targeted case management programs, encourage the staff from those programs to ensure that the scheduled appointments are kept.

Translation Services

Translation services are considered part of the provider's overhead cost and are not separately reimbursable. Providers may not collect payment from a member, or authorized person acting on behalf of the member, for translation services.

Providers should call the Affirmative Action and Civil Rights Compliance Officer at 608-266-9372 for information about when

translation services are required by federal law. Providers may also write to the following address:

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

Topic #1523

Transportation to Medical Appointments

Although transportation is not a covered service for PNCC (prenatal care coordination) providers, providers often assist members with making transportation arrangements.

NEMT (non-emergency medical transportation) services are provided to most members through MTM Inc. (Medical Transportation Management Inc.) Refer to the NEMT service area for complete policy and program information. All providers may be asked to verify that the member received covered services at their site on a particular date.

Screening, Brief Intervention, and Referral to Treatment Benefit

Topic #8297

An Overview

Definition

The SBIRT (Screening, Brief Intervention, and Referral to Treatment) benefit is covered for members enrolled in BadgerCare Plus and Wisconsin Medicaid. Members enrolled in an HMO must receive the services through the HMO. This benefit applies to members who are 10 years of age or older on the DOS (date of service). These services do not require PA (prior authorization) and are not subject to copayment.

The purpose of the SBIRT benefit is to identify and assist members at risk for substance abuse problems. The benefit has two components:

- Screening for substance abuse problems
- Brief preventive substance abuse intervention for members identified as being at risk for having substance abuse disorders

The substance abuse screening and intervention services are designed to prevent members from developing a substance abuse disorder. These services are not intended to address tobacco abuse. These services are not intended to treat members diagnosed with a substance abuse disorder or to treat members already receiving substance abuse treatment services. Members identified through the screening and intervention process as needing more extensive or specialized treatment should be referred to an appropriate substance abuse program. A physician's prescription is not required for SBIRT services.

To be reimbursable, SBIRT services must be provided on a face-to-face basis (either in person or via simultaneous audio and video transmission).Telephone and internet-based communications with members are not covered.

Members who are pregnant are eligible for substance abuse screening and intervention services through a separate benefit designed specifically for pregnant women. ForwardHealth will not cover both benefits during the member's pregnancy. Providers are required to use either the benefit for pregnant women or the SBIRT benefit for the substance abuse screening and intervention services.

Substance Abuse Screening

Substance abuse screening is a method for identifying people who use alcohol or drugs in a way that puts them at risk for problems or injuries related to their substance use. Wisconsin Medicaid and BadgerCare Plus cover substance abuse screening in a wide variety of settings to increase the chance of identifying people at risk. Screening is also a part of primary prevention aimed at educating members about the health effects of using alcohol and other drugs.

Providers are required to use an evidence-based screening tool to identify members at risk for substance abuse problems. A few brief questions on substance use may be asked to identify those individuals likely to need a more in-depth screening. Those brief screening questions, however, do not meet the criteria for reimbursement for this benefit. The screening tool must demonstrate sufficient evidence that it is valid and reliable to identify individuals at risk for a substance abuse disorder and provide enough information to tailor an appropriate intervention to the identified level of substance use. The areas that must be covered include:

- The quantity and frequency of substance use
- Problems related to substance use
- Dependence symptoms

- Injection drug use

The screening tool should be simple enough to be administered by a wide range of health care professionals. It should also focus on the frequency and the quantity of substance use over a particular time frame (generally 1 to 12 months).

Below is a listing of evidence-based substance abuse screening tools that meet the criteria for reimbursement for this benefit. Providers may choose tools that are not included on the list as long as they meet the criteria above. In addition, providers must obtain prior approval from the Wisconsin DHS (Department of Health Services) before using a tool that is not listed below. Contact DHS at **DHSSBIRT@wisconsin.gov** for additional information. The approved tools include the following:

- The AUDIT (Alcohol Use Disorders Inventory Test). This screen is a reliable tool for use to determine the level of alcohol use. The AUDIT screen is available through the WHO (World Health Organization) Web site.
- The DAST (Drug Abuse Screening Test). This screening tool is a reliable tool to use to determine the level of drug use. The DAST screen is available through the Dr. Alan Tepp, Ph. D., website.
- The ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test). This screen is available through the WHO website.
- The CRAFFT screening tool developed by John Knight at the CeASAR (Center for Adolescent Substance Abuse Research). The CRAFFT screening tool is available through the CeASAR website. This screen is valid for use with children and adolescents.
- The POSIT (Problem Oriented Screening Instrument for Teenagers). This screen is valid for use in adolescents in a medical setting. A POSIT PC tool is available through the POSIT PC website.

Providers may use more than one screening tool during the screening process when appropriate; however, there is no additional reimbursement for using more than one screening tool.

Substance Abuse Intervention

Brief substance abuse intervention services are covered for members who are identified through the use of an evidence-based screening tool as being at risk for substance abuse disorder(s). The purpose of the intervention is to motivate the member to decrease or abstain from alcohol consumption and/or drug use. Brief intervention may be a single session or multiple sessions using a motivational discussion that focuses on increasing insight and awareness regarding substance use and increasing motivation toward behavioral change. Brief intervention can also be used for those in need of more extensive levels of care, as a method of increasing motivation and acceptance of a referral to specialty substance abuse treatment.

Wisconsin Medicaid and BadgerCare Plus cover brief intervention services provided during the same visit as the screening or during a separate visit. The brief intervention is not covered for members who have not had a substance abuse screen.

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

Examples of effective strategies for the intervention services include the following:

- The SBIRT protocols. The SBIRT protocols are available through the U.S. Department of Health and Human Services.
- "Helping Patients Who Drink Too Much," A Clinician's Guide, Updated 2005 Edition, available through the U.S. Department of Health and Human Services.

Topic #8337

Coverage Limitations

Substance Abuse Screening

For members enrolled in BadgerCare Plus or Wisconsin Medicaid, the screening is limited to one unit of service per rolling 12 months. A unit of service is equivalent to the total amount of time required to administer the screening.

The screening is not considered part of the mental health and substance abuse services available under ForwardHealth. The screening is not counted towards any service limitations or PA (prior authorization) thresholds for those services.

Substance Abuse Intervention

For members enrolled in BadgerCare Plus and Wisconsin Medicaid, the intervention services are limited to four hours per rolling 12 months. A unit of service is 15 minutes, so the four-hour limit is equal to 16 units of service.

Only one hour (up to four units of service) can be billed on one DOS (date of service). The intervention services may be provided on the same DOS or on a later DOS than the screening.

The intervention services are not considered part of the mental health and substance abuse services available under ForwardHealth and are not counted towards any service limitations or PA thresholds for those services.

Topic #8338

Documentation Requirements

In addition to documenting the service provided, providers are required to keep a copy of the completed screening tool(s) in the member's medical record. Providers using electronic medical records should make a note of which screening tool was used if they do not have an electronic version of the tool, and note the member's responses to the screening questions. Providers are also required to retain documents concerning the provider's education, training, and supervision.

Refer to the Documentation chapter of the Provider Enrollment and Ongoing Responsibilities section of the appropriate Online Handbook for more information about additional documentation requirements.

Topic #8317

Eligible Providers

Early detection of substance abuse problems is crucial to successfully treating members. It is also important for members to obtain referrals for follow-up care when appropriate. In order to accomplish these goals, BadgerCare Plus and Wisconsin Medicaid are allowing a wide range of Medicaid-enrolled providers to administer the SBIRT (Screening, Brief Intervention, and Referral to Treatment) services.

The following table lists providers eligible to receive reimbursement for the screening and the substance abuse intervention services.

Provider Type	Eligible for Reimbursement of Services Provided Under the SBIRT benefit?
Advanced practice nurse prescribers with psychiatric specialty	Allowed
Crisis intervention providers	Allowed
HealthCheck providers	Allowed
Master's-level psychotherapists in outpatient mental health	Allowed when provided in conjunction with a primary care, hospital,

or substance abuse clinics	and/or emergency room visit
Nurse practitioners	Allowed
Physicians	Allowed
Physicians assistants	Allowed
Prenatal care coordination providers	Allowed
Psychiatrists	Allowed
Psychologists in outpatient mental health or substance abuse clinics	Allowed when provided in conjunction with a primary care, hospital, and/or emergency room visit
Substance abuse counselors in outpatient mental health or substance abuse clinics	Allowed when provided in conjunction with a primary care, hospital, and/or emergency room visit

Providers are required to retain documents showing that staff providing substance abuse screening and intervention services meet the training, education, and supervision requirements.

Requirements for Licensed Individuals

Licensed health care professionals must complete the Wisconsin DHS (Department of Health Services)-approved training to directly deliver the screening and intervention services. Training for licensed professionals must extend at least 4 hours and may be conducted in person or via the internet. DHS may exempt licensed professionals with expertise in the field of substance abuse screening and motivational enhancement or motivational interviewing on a case by case basis.

Providers should contact the DHS at **DHSSBIRT@wisconsin.gov** for more information about the required training or to find out if they can be exempted from the training requirements.

Requirements for Unlicensed Individuals

Unlicensed individuals may provide screening or brief intervention services if they meet all of the following criteria:

- Successfully complete at least 60 hours of training related to providing screening and brief intervention for alcohol and substance abuse (other than tobacco). This training includes the DHS-approved training to deliver the screening and intervention services. At least 30 hours of training must be conducted in person.
- Provide the screening and intervention services under the supervision of a licensed health care professional.
- Follow written or electronic protocols for evidence-based practice during the delivery of screening and intervention services. Protocols must be consistently followed, so the licensed health care professional must ensure that quality assurance procedures are in place for the written or electronic protocols.

Topic #8318

Procedure Codes and Diagnosis Codes

The following tables list the HCPCS (Healthcare Common Procedure Coding System) procedure codes and applicable diagnosis codes that providers are required to use when submitting claims for substance abuse screening and substance abuse intervention services under the SBIRT (Screening, Brief Intervention, and Referral to Treatment) benefit.

Place of Service Codes (Submitted on the 1500 Health Insurance Claim Form ((02/12)))	
03	School

11	Office
12	Home
19	Off Campus — Outpatient Hospital
21	Inpatient Hospital
22	On Campus — Outpatient Hospital
23	Emergency Room — Hospital
99	Other Place of Service

Substance Abuse Screening and Intervention Services				
Procedure Code	**Description**	**Limitations (Medicaid and BadgerCare Plus)**	**Allowable Place of Service**	**Allowable Diagnosis Code**
H0049	Alcohol and/or drug screening	Limited to one unit per member, per rolling 12 months.	03, 11, 12, 19, 21, 22, 23, 99	Z13.9 (Encounter for screening, unspecified)
H0050	Alcohol and/or drug service, brief intervention, per 15 minutes	Limited to 16 units per member, per rolling 12 months.	03, 11, 12, 19, 21, 22, 23, 99	Z71.89 (Other specified counseling)

Managed Care

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Archive Date:10/01/2021

Managed Care:Covered and Noncovered Services

Topic #16197

Care4Kids Program Benefit Package

Covered Services

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

Noncovered Services

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

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

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

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

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

Managed Care Information

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

Member Information

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Archive Date:10/01/2021

Member Information:Enrollment Categories

Topic #225

BadgerCare Plus

Populations Eligible for BadgerCare Plus

The following populations are eligible for BadgerCare Plus:

- Parents and caretakers with incomes at or below 100 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 #228

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for selected groups of people who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP (Wisconsin Medical Assistance Program), MA (Medical Assistance), Title XIX, or T19.

A Medicaid member is any individual entitled to benefits under Title XIX of the Social Security Act and under the Medical Assistance State Plan as defined in Wis. Stat. ch. 49.

Wisconsin Medicaid enrollment is determined on the basis of financial need and other factors. A citizen of the United States or a "qualified immigrant" who meets low-income financial requirements may be enrolled in Wisconsin Medicaid if they are in one of the following categories:

- Age 65 and older
- Blind
- Disabled

Some needy and low-income people become eligible for Wisconsin Medicaid by qualifying for programs such as:

- Katie Beckett
- Medicaid Purchase Plan
- Subsidized adoption and foster care programs
- SSI (Supplemental Security Income)
- WWWP (Wisconsin Well Woman Program)

Providers may advise these individuals or their representatives to contact their certifying agency for more information. The following agencies certify people for Wisconsin Medicaid enrollment:

- Income maintenance or tribal agencies
- Medicaid outstation sites
- SSA (Social Security Administration) offices

In limited circumstances, some state agencies also certify individuals for Wisconsin Medicaid.

Medicaid fee-for-service members receive services through the traditional health care payment system under which providers receive a payment for each unit of service provided. Some Medicaid members receive services through state-contracted MCOs (managed care organizations).

Topic #18777

Real-Time Eligibility Determinations

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

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

Eligibility Verification

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

On rare occasions, it may take up to 48 hours for eligibility information to be available through interChange. In such instances, if a member presents a valid temporary ID card, **the provider is still required to provide services**, even if eligibility cannot be verified through EVS.

Sample Temporary Identification Card for Badger Care Plus

To the Provider

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

NOTE:

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

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR BADGERCARE PLUS

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

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

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

SAMPLE

Sample Temporary Identification Card for Family Planning Only Services

To the Provider

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

NOTE:

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

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR FAMILY PLANNING ONLY SERVICES

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

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

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

SAMPLE

Topic #240

Wisconsin Well Woman Medicaid

Wisconsin Well Woman Medicaid provides full Medicaid benefits to underinsured or uninsured women ages 35 to 64 who have been screened and diagnosed by WWWP (Wisconsin Well Woman Program) or Family Planning Only Services, meet all other enrollment requirements, and are in need of treatment for any of the following:

- Breast cancer
- Cervical cancer
- Precancerous conditions of the cervix

Services provided to women who are enrolled in WWWMA (Wisconsin Well Woman Medicaid) are reimbursed through Medicaid fee-for-service.

Enrollment Responsibilities

Topic #241

General Information

Members have certain responsibilities per Wis. Admin. Code § DHS 104.02 and the ForwardHealth Enrollment and Benefits (P-00079 (07/14)) booklet.

Topic #243

Loss of Enrollment — Financial Liability

Some covered services consist of a series of sequential treatment steps, meaning more than one office visit is required to complete treatment.

In most cases, if a member loses enrollment midway through treatment, BadgerCare Plus and Medicaid will **not** reimburse services (including prior authorized services) after enrollment has lapsed.

Members are financially responsible for any services received after their enrollment has been terminated. If the member wishes to continue treatment, it is a decision between the provider and the member whether the service should be given and how the services will be paid. The provider may collect payment from the member if the member accepts responsibility for payment of a service and certain conditions are met.

To avoid misunderstandings, it is recommended that providers remind members that they are financially responsible for any continued care after enrollment ends.

To avoid potential reimbursement problems that can arise when a member loses enrollment midway through treatment, the provider is encouraged to verify the member's enrollment using the EVS (Enrollment Verification System) or the ForwardHealth Portal prior to providing each service, even if an approved PA (prior authorization) request is obtained for the service.

Topic #707

Member Cooperation

Members are responsible for giving providers full and accurate information necessary for the correct submission of claims. If a member has other health insurance, it is the member's obligation to give full and accurate information to providers regarding the insurance.

Topic #269

Members Should Present Card

It is important that providers determine a member's enrollment and other insurance coverage **prior to** each DOS (date of service) that services are provided. Pursuant to Wis. Admin. Code § DHS 104.02(2), a member should inform providers that they are enrolled in BadgerCare Plus or Wisconsin Medicaid and should present a current ForwardHealth identification card before

receiving services.

Note: Due to the nature of their specialty, certain providers — such as anesthesiologists, radiologists, DME (durable medical equipment) suppliers, independent laboratories, and ambulances — are not always able to see a member's ForwardHealth identification card because they might not have direct contact with the member prior to providing the service. In these circumstances, it is still the provider's responsibility to obtain member enrollment information.

Topic #244

Prior Identification of Enrollment

Except in emergencies that preclude prior identification, members are required to inform providers that they are receiving benefits and must present their ForwardHealth identification card before receiving care. If a member forgets their ForwardHealth card, providers may verify enrollment without it.

Topic #245

Reporting Changes to Caseworkers

Members are required to report certain changes to their caseworker at their certifying agency. These changes include, but are not limited to, the following:

- A new address or a move out of state
- A change in income
- A change in family size, including pregnancy
- A change in other health insurance coverage
- Employment status
- A change in assets for members who are over 65 years of age, blind, or disabled

Enrollment Rights

Topic #246

Appealing Enrollment Determinations

Applicants and members have the right to appeal certain decisions relating to BadgerCare Plus, Medicaid, or ADAP (Wisconsin AIDS Drug Assistance Program) enrollment. An applicant, a member, or authorized person acting on behalf of the applicant or member, or former member may file the appeal with the DHA (Division of Hearings and Appeals).

Pursuant to Wis. Admin. Code § HA 3.03, an applicant, member, or former member may appeal any adverse action or decision by an agency or department that affects their benefits. Examples of decisions that may be appealed include, but are not limited to, the following:

- Individual was denied the right to apply.
- Application for BadgerCare Plus, ADAP, or Wisconsin Medicaid was denied.
- Application for BadgerCare Plus, ADAP, or Wisconsin Medicaid was not acted upon promptly.
- Enrollment was unfairly discontinued, terminated, suspended, or reduced.

In the case when enrollment is cancelled or terminated, the date the member, or authorized person acting on behalf of the member, files an appeal with the DHA determines what continuing coverage, if any, the member will receive until the hearing decision is made. The following scenarios describe the coverage allowed for a member who files an appeal:

- If a member files an appeal before his or her enrollment ends, coverage will continue pending the hearing decision.
- If a member files an appeal within 45 days after his or her enrollment ends, a hearing is allowed but coverage is not reinstated.

If the member files an appeal more than 45 days after his or her enrollment ends, a hearing is not allowed. Members may file an appeal by submitting a Request for Fair Hearing (DHA-28 (08/09)) form.

Claims for Appeal Reversals

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

If a claim is denied due to termination of BadgerCare Plus or Wisconsin Medicaid enrollment, a hearing decision that reverses that determination will allow the claim to be resubmitted and paid. The provider is required to obtain a copy of the appeal decision from the member, attach the copy to the previously denied claim, and submit both to ForwardHealth at the following address:

ForwardHealth
Specialized Research
Ste 50
313 Blettner Blvd
Madison WI 53784

If a provider has not yet submitted a claim, the provider is required to submit a copy of the hearing decision along with a paper claim to Specialized Research.

As a reminder, claims submission deadlines still apply even to those claims with hearing decisions.

Claim Denial Due to Termination of ADAP Enrollment

If a claim is denied due to termination of ADAP enrollment, a hearing decision that reverses that determination will allow the claim to be resubmitted and paid. The provider is required to obtain a copy of the appeal decision from the member, attach the copy to the previously denied claim, and submit both to ForwardHealth at the following address:

ForwardHealth
ADAP Claims and Adjustments
PO Box 8758
Madison WI 53708

If a provider has not yet submitted a claim, the provider is required to submit a copy of the hearing decision along with a paper claim to ADAP Claims and Adjustments.

As a reminder, claims submission deadlines still apply even to those claims with hearing decisions.

Topic #247

Freedom of Choice

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

Topic #975

For members, participation in the PNCC (prenatal care coordination) program is voluntary. The member voluntarily participates in the program by maintaining contact with and receiving services from the care coordination provider. The care coordination provider may not "lock-in" members or deny the member's freedom to choose providers. Members may participate, to the full extent of their ability, in all decisions regarding appropriate services and providers.

Topic #248

General Information

Members are entitled to certain rights per Wis. Admin. Code ch. DHS 103.

Topic #250

Notification of Discontinued Benefits

When DHS (Department of Health Services) intends to discontinue, suspend, or reduce a member's benefits, or reduce or eliminate coverage of services for a general class of members, DHS sends a written notice to members. This notice is required to be provided at least 10 days before the effective date of the action.

Topic #252

Prompt Decisions on Enrollment

Individuals applying for BadgerCare Plus or Wisconsin Medicaid have the right to prompt decisions on their applications.

Enrollment decisions are made within 60 days of the date the application was signed for those with disabilities and within 30 days for all other applicants.

Topic #254

Requesting Retroactive Enrollment

An applicant has the right to request retroactive enrollment when applying for BadgerCare Plus or Wisconsin Medicaid. Enrollment may be backdated to the first of the month three months prior to the date of application for eligible members. Retroactive enrollment does not apply to QMB-Only (Qualified Medicare Beneficiary-Only) members.

Identification Cards

Topic #266

ForwardHealth Identification Cards

Each enrolled member receives an identification card. Possession of a program identification card does not guarantee enrollment. It is possible that a member will present a card during a lapse in enrollment; therefore, it is essential that providers verify enrollment before providing services. Members are told to keep their cards even though they may have lapses in enrollment.

ForwardHealth Identification Card Features

The ForwardHealth identification card includes the member's name, 10-digit member ID, magnetic stripe, signature panel, and the Member Services telephone number. The card also has a unique, 16-digit card number on the front for internal program use.

The ForwardHealth card does not need to be signed to be valid; however, adult members are encouraged to sign their cards. Providers may use the signature as another means of identification.

The toll-free number on the back of each of the cards is for member use only. The address on the back of each card is used to return a lost card to ForwardHealth if it is found.

If a provider finds discrepancies with the identification number or name between what is indicated on the ForwardHealth card and the provider's file, the provider should verify enrollment with Wisconsin's EVS (Enrollment Verification System).

Identification Number Changes

Some providers may question whether services should be provided if a member's 10-digit identification number on their ForwardHealth card does not match the EVS response. If the EVS indicates the member is enrolled, services should be provided.

A member's identification number may change, and the EVS will reflect that change. However, ForwardHealth does not automatically send a replacement ForwardHealth card with the new identification number to the member. ForwardHealth cross-references the old and new identification numbers so a provider may submit claims with either number. The member may request a replacement ForwardHealth card that indicates the new number.

Member Name Changes

If a member's name on the ForwardHealth card is different than the response given from Wisconsin's EVS, providers should use the name from the EVS response. When a name change is reported and on file, a new card will automatically be sent to the member.

Deactivated Cards

When any member identification card has been replaced for any reason, the previous identification card is deactivated. If a member presents a deactivated card, providers should encourage the member to discard the deactivated card and use only the new card.

Although a member identification card may be deactivated, the member ID is valid and the member still may be enrolled in a ForwardHealth program.

If a provider swipes a ForwardHealth card using a magnetic stripe card reader and finds that it has been deactivated, the provider may request a second form of identification if they do not know the member. After the member's identity has been verified, providers may verify a member's enrollment by using one of the EVS methods such as AVR (Automated Voice Response).

Defective Cards

If a provider uses a card reader for a ForwardHealth card and the magnetic stripe is defective, the provider should encourage the member to call Member Services at the number listed on the back of the member's card to request a new card.

If a member presents a ForwardHealth card with a defective magnetic stripe, providers may verify the member's enrollment by using an alternate enrollment verification method. Providers may also verify a member's enrollment by entering the member ID or 16-digit card number on a touch pad, if available, or by calling WiCall or Provider Services.

Lost Cards

If a member needs a replacement ForwardHealth card, they may call Member Services to request a new one.

If a member lost their ForwardHealth card or never received one, the member may call Member Services to request a new one.

Managed Care Organization Enrollment Changes

Members do not receive a new ForwardHealth card if they are enrolled in a state-contracted MCO (managed care organization) or change from one MCO to another. Providers should verify enrollment with the EVS every time they see a member to ensure they have the most current managed care enrollment information.

Topic #1435

Types of Identification Cards

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

Misuse and Abuse of Benefits

Topic #271

Examples of Member Abuse or Misuse

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

Topic #274

Pharmacy Services Lock-In Program

Overview of the Pharmacy Services Lock-In Program

The purpose of the Pharmacy Services Lock-In Program is to coordinate the provision of health care services for members who abuse or misuse Medicaid, BadgerCare Plus, or SeniorCare benefits by seeking duplicate or medically unnecessary services, particularly for controlled substances. The Pharmacy Services Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in Wis. Admin. Code § DHS 104.02.

Coordination of member health care services is intended to:

- Curb the abuse or misuse of controlled substance medications.
- Improve the quality of care for a member.
- Reduce unnecessary physician utilization.

The Pharmacy Services Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in Wis. Admin. Code § DHS 104.02. The abuse and misuse definition includes:

- Not duplicating or altering prescriptions
- Not feigning illness, using false pretense, providing incorrect enrollment status, or providing false information to obtain service
- Not seeking duplicate care from more than one provider for the same or similar condition
- Not seeking medical care that is excessive or not medically necessary

The Pharmacy Services Lock-In Program applies to members in fee-for-service as well as members enrolled in Medicaid SSI HMOs and BadgerCare Plus HMOs. Members remain enrolled in the Pharmacy Services Lock-In Program for two years and are continuously monitored for their prescription drug usage. At the end of the two-year enrollment period, an assessment is made to determine if the member should continue enrollment in the Pharmacy Services Lock-In Program.

Members enrolled in the Pharmacy Services Lock-In Program will be locked into one pharmacy where prescriptions for restricted medications must be filled and one prescriber who will prescribe restricted medications. Restricted medications are most controlled substances, carisoprodol, and tramadol. Referrals will be required only for restricted medication services.

Fee-for-service members enrolled in the Pharmacy Services Lock-In Program may choose physicians and pharmacy providers from whom to receive prescriptions and medical services not related to restricted medications. Members enrolled in an HMO must comply with the HMO's policies regarding care that is not related to restricted medications.

Referrals of members as candidates for lock-in are received from retrospective DUR (Drug Utilization Review), physicians, pharmacists, other providers, and through automated surveillance methods. Once a referral is received, six months of pharmacy claims and diagnoses data are reviewed. A recommendation for one of the following courses of action is then made:

- No further action.
- Send an intervention letter to the physician.
- Send a warning letter to the member.
- Enroll the member in the Pharmacy Services Lock-In Program.

Medicaid, BadgerCare Plus, and SeniorCare members who are candidates for enrollment in the Pharmacy Services Lock-In Program are sent a letter of intent, which explains the restriction that will be applied, how to designate a primary prescriber and a pharmacy, and how to request a hearing if they wish to contest the decision for enrollment (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 HID (Health Information Designs, Inc.). HID may be contacted by telephone at 800-225-6998, extension 3045, by fax at 800-881-5573, or by mail at the following address:

Pharmacy Services Lock-In Program
c/o Health Information Designs
391 Industry Dr
Auburn AL 36832

Pharmacy Services Lock-In Prescribers Are Required to Be Enrolled in Wisconsin Medicaid

To prescribe restricted medications for Pharmacy Services Lock-In Program members, prescribers are required to be enrolled in Wisconsin Medicaid. Enrollment for the Pharmacy Services Lock-In Program is not separate from enrollment in Wisconsin Medicaid.

Role of the Lock-In Prescriber and Pharmacy Provider

The Lock-In prescriber determines what restricted medications are medically necessary for the member, prescribes those

medications using his or her professional discretion, and designates an alternate prescriber if needed. If the member requires an alternate prescriber to prescribe restricted medications, the primary prescriber should complete the Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services (F-11183 (05/2015)) form and return it to the Pharmacy Services Lock-In Program and to the member's HMO, if applicable.

To coordinate the provision of medications, the Lock-In prescriber may also contact the Lock-In pharmacy to give the pharmacist(s) guidelines as to which medications should be filled for the member and from whom. The primary Lock-In prescriber should also coordinate the provision of medications with any other prescribers he or she has designated for the member.

The Lock-In pharmacy fills prescriptions for restricted medications that have been written by the member's Lock-In prescriber(s) and works with the Lock-In prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The Lock-In pharmacy may fill prescriptions for medications from prescribers other than the Lock-In prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated Lock-In prescriber, the claim will be denied.

Designated Lock-In Pharmacies

The Pharmacy Services Lock-In Program pharmacy fills prescriptions for restricted medications that have been written by the member's Lock-In prescriber(s) and works with the Lock-In prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The Lock-In pharmacy may fill prescriptions for medications from prescribers other than the Lock-In prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated Lock-In prescriber, the claim will be denied.

Alternate Providers for Members Enrolled in the Pharmacy Services Lock-In Program

Members enrolled in the Pharmacy Services Lock-In Program do not have to visit their Lock-In prescriber to receive medical services unless an HMO requires a primary care visit. Members may see other providers to receive medical services; however, other providers cannot prescribe restricted medications for Pharmacy Services Lock-In Program members unless specifically designated to do so by the primary Lock-In prescriber. For example, if a member sees a cardiologist, the cardiologist may prescribe a statin for the member, but the cardiologist may not prescribe restricted medications unless he or she has been designated by the Lock-In prescriber as an alternate provider.

A referral to an alternate provider for a Pharmacy Services Lock-In Program member is necessary only when the member needs to obtain a prescription for a restricted medication from a provider other than his or her Lock-In prescriber or Lock-In pharmacy.

If the member requires alternate prescribers to prescribe restricted medications, the primary Lock-In prescriber is required to complete the Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services form. Referrals for fee-for-service members must be on file with the Pharmacy Services Lock-In Program. Referrals for HMO members must be on file with the Pharmacy Service Lock-In Program and the member's HMO.

Designated alternate prescribers are required to be enrolled in Wisconsin Medicaid.

Claims from Providers Who Are Not Designated Pharmacy Services Lock-In Providers

If the member brings a prescription for a restricted medication from a non-Lock-In prescriber to the designated Lock-In pharmacy, the pharmacy provider cannot fill the prescription.

If a pharmacy claim for a restricted medication is submitted from a provider who is not the designated Lock-In prescriber, alternate prescriber, Lock-In pharmacy, or alternate pharmacy, the claim will be denied. If a claim is denied because the

prescription is not from a designated Lock-In prescriber, the Lock-In pharmacy provider cannot dispense the drug or collect a cash payment from the member because the service is a nonreimbursable service. However, the Lock-In pharmacy provider may contact the Lock-In prescriber to request a new prescription for the drug, if appropriate.

To determine if a provider is on file with the Pharmacy Services Lock-In Program, the Lock-In pharmacy provider may do one of the following:

- Speak to the member.
- Call HID.
- Call Provider Services.
- Use the ForwardHealth Portal.

Claims are not reimbursable if the designated Lock-In prescriber, alternate Lock-In prescriber, Lock-In pharmacy, or alternate Lock-In pharmacy provider is not on file with the Pharmacy Services Lock-In Program.

For More Information

Providers may call HID with questions about the Pharmacy Services Lock-In Program. Pharmacy providers may also refer to the list of restricted medications data table or call Provider Services with questions about the following:

- Drugs that are restricted for Pharmacy Services Lock-In Program members
- A member's enrollment in the Pharmacy Services Lock-In program
- A member's designated Lock-In prescriber or Lock-In pharmacy

Topic #273

Providers May Refuse to Provide Services

Providers may refuse to provide services to a BadgerCare Plus or Medicaid member in situations when there is reason to believe that the person presenting the ForwardHealth identification card is misusing or abusing it.

Members who abuse or misuse BadgerCare Plus or Wisconsin Medicaid benefits or their ForwardHealth card may have their benefits terminated or be subject to limitations under the Pharmacy Services Lock-In Program or to criminal prosecution.

Topic #275

Requesting Additional Proof of Identity

Providers may request additional proof of identity from a member if they suspect fraudulent use of a ForwardHealth identification card. If another form of identification is not available, providers can compare a person's signature with the signature on the back of the ForwardHealth identification card if it is signed. (Adult members are encouraged to sign the back of their cards; however, it is not mandatory for members to do so.)

Verifying member identity, as well as enrollment, can help providers detect instances of fraudulent ForwardHealth card use.

Special Enrollment Circumstances

Topic #276

Medicaid Members from Other States

Wisconsin Medicaid does not pay for services provided to members enrolled in other state Medicaid programs. Providers are advised to contact other state Medicaid programs to determine whether the service sought is a covered service under that state's Medicaid program.

Topic #279

Members Traveling Out of State

When a member travels out of state but is within the United States (including its territories), Canada, or Mexico, BadgerCare Plus and Wisconsin Medicaid cover medical services in any of the following circumstances:

- An emergency illness or accident
- When the member's health would be endangered if treatment were postponed
- When the member's health would be endangered if travel to Wisconsin were undertaken
- When PA (prior authorization) has been granted to the out-of-state provider for provision of a nonemergency service
- When there are coinsurance, copayment, or deductible amounts remaining after Medicare payment or approval for dual eligibles

Note: Some providers located in a state that borders Wisconsin may be Wisconsin Medicaid enrolled as a border-status provider if the provider notifies ForwardHealth in writing that it is common practice for members in a particular area of Wisconsin to seek their medical services. Border-status providers follow the same policies as Wisconsin providers.

Topic #552

Newborn Reporting

Hospitals, physicians, nurse practitioners, nurse midwives, licensed midwives, and BadgerCare Plus or Medicaid HMOs may submit newborn reports to report babies born to mothers enrolled in BadgerCare Plus or Medicaid at the time of birth. Timely reporting of newborns ensures that there will be no delay in receiving important services.

Physicians, nurse practitioners, nurse midwives, and licensed midwives should report newborns **only** if the mother is **not** enrolled in a BadgerCare Plus HMO and the birth occurs outside a hospital setting. Otherwise, the hospital **or** BadgerCare Plus HMO should report the birth. If a mother is enrolled in a BadgerCare Plus HMO but has her baby outside the HMO network, the hospital provider or HMO is responsible for reporting the birth to ForwardHealth.

Hospitals, providers, or HMOs should complete and submit **one** newborn report per newborn, depending on the enrollment status of the mother. For example, if the mother is enrolled in an HMO, the HMO **or** the hospital should report the newborn. Providers should not submit reports as long as the HMO or the hospital is reporting the newborn.

Newborns should be reported to ForwardHealth even in instances in which the baby is born alive but does not survive or if the baby is not staying with the mother after birth.

Newborn Report Submission

Providers are encouraged to submit a newborn report soon after a baby is born to avoid a delay in establishing the baby's enrollment in BadgerCare Plus or the mother's BadgerCare Plus HMO. Before completing a newborn report, providers should verify that the baby has not already been enrolled. This verification could save time and avoid the possibility of the baby having multiple records.

Providers should not use the EE (Express Enrollment) process if the mother is enrolled in BadgerCare Plus or Medicaid at the time of birth.

Providers may report the birth of a baby by submitting the Newborn Report (F-01165 (09/2019)) form or submitting the information in another format as long as all information required on the Newborn Report form is provided. Required information includes the following:

- Provider's name
- Contact name and telephone number
- Baby's last name
- Baby's gender
- Baby's date of birth (in MM/DD/CCYY format)
- Indication if newborn weight is less than 1200 grams
- Newborn weight*
- Gestational age*
- Mother's full name
- Mother's member ID number
- Mother's full address
- Provider representative signature
- Date the report was completed

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

Providers are required to report each baby separately.

Newborn reports may be submitted by fax to (608) 224-6318 or by mail to the following address:

ForwardHealth
PO Box 6470
Madison WI 53716

For privacy and security purposes, providers should **not** submit newborn reports via e-mail.

If incomplete information is provided or if multiple babies are listed on one newborn report, the report will be returned to the contact person indicated on the report in the manner in which it was submitted.

Newborn reports should be submitted only for babies born to women enrolled in BadgerCare Plus or Medicaid.

Reporting a Newborn's Name

Although the baby's first name may not be available at the time the newborn report is ready to be submitted, **every** effort should be made to provide the first name, rather than a generic "Girl," "Boy," or "Baby." The first name is important in order to prevent assigning multiple ID numbers to the same baby and to ensure that the name is included on the ForwardHealth ID card. Since the baby's eligibility is backdated to the date of birth, delaying the submission of the report for a short time to include all information

will not affect payment of services.

Providers are required to indicate a baby's last name on the report.

Newborn Report Procedures

Once the completed newborn report is submitted, the following procedures take place:

- A ForwardHealth ID number is assigned to the newborn if there is not an existing ID number on file.
- A ForwardHealth card is issued to the child as soon as the child's BadgerCare Plus enrollment is put on file.
- A letter is sent to the child's primary casehead, notifying them of the child's enrollment.

Babies Born to Mothers Not Enrolled in BadgerCare Plus or Medicaid

If a mother was not enrolled in BadgerCare Plus or Medicaid at the time of birth, providers should not report the newborn. The mother may apply for eligibility for her baby through her income maintenance or tribal agency. The newborn may also be enrolled through the EE process.

If the mother was not enrolled in BadgerCare Plus or Medicaid at the time of birth, she can apply for benefits retroactively. If her dates of enrollment include the date of the baby's birth, her baby may also be able to receive retroactive and continuous enrollment for the first year of life.

Providers with questions regarding newborn enrollment or newborn reporting may call Provider Services.

Topic #277

Non-U.S. Citizens — Emergency Services

Certain non-U.S. citizens who are not qualified aliens are eligible for services only in cases of acute emergency medical conditions. Providers should use the appropriate diagnosis code to document the nature of the emergency.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of such severity that one could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the person's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Due to federal regulations, BadgerCare Plus and Wisconsin Medicaid do not cover services for non-U.S. citizens who are not qualified aliens related to routine prenatal or postpartum care, major organ transplants (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 #16657

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

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

Eligibility

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.

To qualify for BadgerCare Plus or Wisconsin Medicaid, prison or jail inmates must meet all applicable eligibility criteria. The DOC coordinates and reimburses inpatient hospital services for state prison inmates who do not qualify for BadgerCare Plus or Wisconsin Medicaid.

Inmates whose BadgerCare Plus or Wisconsin Medicaid eligibility has been suspended will have coverage of inpatient services for the duration of a hospital stay of 24 hours or more. This coverage begins on their date of admission and ends on their date of discharge.

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

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

Enrollment

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

Covered Services

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

Fee-for-Service

Inmates receive services on a fee-for-service basis; they are not enrolled in HMOs.

Prior Authorization

The DOC will assist inpatient hospital providers with their submission of PA (prior authorization) requests for any services requiring PA. If PA is denied, the DOC is responsible for reimbursement of the services.

Enrollment Verification

Inmates are only enrolled for the duration of their hospital stay. Providers should always verify an inmate's enrollment in BadgerCare Plus or Wisconsin Medicaid before submitting a claim.

Claim Submission

When submitting a claim for an inmate's inpatient hospital stay, providers should follow the current claim submission procedures for each applicable service area.

Reimbursement

Acute care hospitals that provide services to inmates are reimbursed at a percentage of their usual and customary charge.

Critical access hospitals that provide services to inmates are reimbursed according to their existing Wisconsin Medicaid reimbursement methodology.

Wisconsin Medicaid reimburses professional services related to an inmate's inpatient hospital stay (e.g., laboratory services, physician services, radiology services, or DME (durable medical equipment)) at the current maximum allowable fee.

Contact Information

Providers may contact the DOC at 608-240-5139 or 608-240-5190 with questions regarding enrollment or PA for inmate inpatient hospital stays.

Topic #280

Retroactive Enrollment

Retroactive enrollment occurs when an individual has applied for BadgerCare Plus or Medicaid and enrollment is granted with an effective date prior to the date the enrollment determination was made. A member's enrollment may be backdated to allow retroactive coverage for medical bills incurred prior to the date of application.

The retroactive enrollment period may be backdated up to three months prior to the month of application if all enrollment requirements were met during the period. Enrollment may be backdated more than three months if there were delays in determining enrollment or if court orders, fair hearings, or appeals were involved.

Reimbursing Members in Cases of Retroactive Enrollment

When a member receives retroactive enrollment, he or she has the right to request the return of payments made to a Medicaid-enrolled provider for a covered service during the period of retroactive enrollment, according to Wis. Admin. Code § DHS 104.01(11). A Medicaid-enrolled provider is required to submit claims to ForwardHealth for covered services provided to a member during periods of retroactive enrollment. Medicaid cannot directly refund the member.

If a service(s) that requires PA (prior authorization) was performed during the member's period of retroactive enrollment, the provider is required to submit a PA request and receive approval from ForwardHealth **before** submitting a claim.

If a provider receives reimbursement from Medicaid for services provided to a retroactively enrolled member and the member has paid for the service, the provider is required to reimburse the member or authorized person acting on behalf of the member (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.

Provider Enrollment and Ongoing Responsibilities

6

Archive Date:10/01/2021

Provider Enrollment and Ongoing Responsibilities:Documentation

Topic #6277

1099 Miscellaneous Forms

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

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

Topic #946

Assessment Updates

Providers may update the Prenatal Care Coordination Pregnancy Questionnaire (F-01105 (02/2009)) form as frequently as needed. Providers may also administer other assessment instruments periodically, if appropriate, to determine the member's progress toward meeting established goals.

Providers are required to indicate HCPCS (Healthcare Common Procedure Coding System) procedure code T1016 (Case management, each 15 minutes) and modifier "TH" (Obstetrical treatment/services, prenatal or postpartum) when submitting claims for updates to the Pregnancy Questionnaire and/or administration of other assessments.

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 #947

Care Plan Development

Care planning will be reimbursed as a PNCC (prenatal care coordination) service when provided by qualified staff. Care planning includes developing **and** implementing the care plan. The development of a care plan will be reimbursed for members who are identified as having four or more risk factors on the Prenatal Care Coordination Pregnancy Questionnaire (F-01105 (02/2009)) form or who are under 18 years of age. A completed questionnaire must predate the care plan.

The development of one care plan will be reimbursed for each member, per pregnancy. (Updates to the care plan will be reimbursed under the care coordination procedure code.)

The care coordinator is required to develop an individualized care plan for each eligible member. A specific care plan format is not required, but the care plan must be:

- Developed (or reviewed) and signed or initialed by a qualified professional.
- In writing.
- Based on the results of the Pregnancy Questionnaire.

Providers should note in the care plan if the member does not want to address issues identified in the Pregnancy Questionnaire.

To ensure the member's needs are met, the care plan must:

- Identify needs, problems, necessary services, necessary referrals, and frequency of monitoring.
- Include an array of services regardless of funding sources.

Providers may use the Pregnancy Questionnaire Summary as an aid in identifying the member's unmet needs.

To the maximum extent possible, include the member in the development and any subsequent revisions of the care plan. Include family members and other supportive persons as appropriate. The member and care coordinator who developed the care plan are required to sign and date the plan.

Pregnancy Questionnaire Summary (Sample Format)

(For the Prenatal Care Coordinator to complete)

Mother's name (last, first, middle): Please print. _____

Mother's date of birth: _____ Medicaid ID #: _____

TOTAL ASSESSMENT SCORE: _____

Summary of needs identified in the Pregnancy Questionnaire:

☐ Health education needs (teenaged or older mom)
☐ Difficulty reading English (preferred language? _____)
☐ WIC referral
☐ Child support difficulty
☐ Employment needs

☐ Employment needs
☐ School needs
☐ Housing needs
☐ Client unable to get prenatal care
☐ Lack of knowledge regarding pregnancy, labor & delivery, infant health care, general health positive habits
☐ Health education needs (first-time mom)
☐ Medical conditions identified that make this pregnancy at risk
☐ Poor previous pregnancy experience
☐ Tobacco and/or alcohol use
☐ Nutrition education needs
☐ Insufficient funds for food
☐ Conflict/violence in the home
☐ Poor support system
☐ Suspected abuse: ☐ physical ☐ sexual ☐ emotional
☐ Family has urgent health needs
☐ Child care needs
☐ Transportation needs
☐ Other _____

Name of staff who completed the Pregnancy Questionnaire: _____
Position: _____
Date of screening: _____

Topic #949

Care Plan Updates

Providers are required to review and update the care plan at least every 60 days, or earlier if the member's needs change. The provider and the member are required to sign and date all updates to the care plan. The provider may initial updates to the care plan if a signature page is included in the member's file. Providers are required to keep signed copies of the updates in the member's file.

Providers are required to indicate HCPCS (Healthcare Common Procedure Coding System) procedure code T1016 (Case management, each 15 minutes) and modifier "TH" (Obstetrical treatment/services, prenatal or postpartum) when submitting claims for updates to the care plan.

Care Plan (Sample Format)

Psychosocial Assessment	Yes	No	Recipient's Chief Concern	Yes	No		Yes	No	PREGNANCY OUTCOME
									Date
1. Recipient Very Concerned About Pregnancy			7. Conflict/Violence in the Home			13. Child Care Needs			Pregnancy Ended _____
2. Poor Previous Pregnancy Experience			8. Unable to get Prenatal Care			14. Housing Needs			Postpartal/Family Planning Visit _____
3. Poor Support System			9. Family Has Urgent Health Needs			15. Transportation Needs			Postpartal/WIC Certification _____
4. Depression, Other Mental Health Issues			10. Insufficient Funds of Food			16. School Needs			Infant Certified for WIC _____
5. Drugs/Alcohol/Tobacco Usage			11. Difficulty Obtaining Food Stamps			17. Employment Needs			HealthCheck Referral _____
6. Religious/Ethnic/Cultural Factor Affecting Pregnancy			12. Difficulty Enrolling in WIC			18. Child Support Difficulty			Closed for Care Coordination Services _____

Name — Recipient	Medicaid ID Number	Agency Name

Problems / Concerns	Date Detected	Gestational Age	Actions Take	Resolved / Improved?
POSTPARTUM VISITS AND INFANT CARE REFERRAL				

Care Coordinator Checklist (page 1)

Name — Recipient	Medicaid ID Number	Agency Name

CONTENT OF CARE COORDINATOR VISITS (Please check the activities or items related to that visit.)											
DATE:											
Location of contact: Office visit											
Home visit											
Telephone visit											
Gestational age											
Discuss recipient's concerns											
Follow up on previous referrals											
Continue screening for abuse, stress, need for mental health and social services											
HEALTH PROMOTION / EDUCATION											
Continue nutrition counseling, referral											
Risks to avoid: medications, chemicals, etc.											
Monitor smoking, alcohol, drug use											
Managing common discomforts											
Warning signs of pregnancy											
Promote breastfeeding											
Maternal seatbelt use, infant car seat safety											
Preterm labor symptom recognition											
Preparation for labor/birth											
Promote prenatal/parenting class											
Signs of labor – where/when to go											

Signature											

Care Coordinator Checklist (page 2)

CONTENT OF CARE COORDINATOR VISITS (Please check the activities or items related to that visit.)											
DATE:											
TRANSPORTATION ASSISTANCE											
Contacted county transportation											
Contacted HMO transportation											
Other, specify _____											
CHILD CARE ASSISTANCE											
Contacted county child care assistance											
Other, specify _____											
SPECIAL COMMUNICATIONS											
Contacted county child care assistance											
Received information from primary care provider											
Client needed extra appointment reminders and follow up											
Communications with referral providers											
OTHER _____											
Signature											

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 #928

Electronic

Records kept electronically are subject to the same requirements as those maintained on paper. In addition, the following requirements apply to electronic documentation:

- Providers are required to have a paper or electronic back-up system for electronic documentation. This could include having files saved on disk or CD in case of computer failure.
- For audits conducted by the DMS (Division of Medicaid Services), providers are required to produce paper copies of electronic records upon request.
- Providers are required to have safeguards to prevent unauthorized access to the records.

Providers are required to have the signature of the individual performing each service and maintain each signature in their records. This individual is referred to as the "performer."

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 #1564

Medical Records Requiring a Signature

The following are examples of records requiring either a handwritten or electronic signature:

- Assessments.
- Case plans.
- Progress notes.
- All contacts with, or on behalf of, a member.

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.

Topic #929

Requirements

According to Wis. Admin. Code § DHS 106.02(9), all providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation and records. Providers may keep records in written or electronic formats. If providers keep electronic records, they are required to have hard copies available for review and audit.

As defined in Wis. Admin. Code § DHS 105.52(5), the member's file must include the following information, as appropriate:

- Verification of the member's pregnancy.
- The member's completed Prenatal Care Coordination Pregnancy Questionnaire (F-01105 (02/2009)) form. The questionnaire must be scored, signed, and dated. The member's care plan, signed and dated as required. The provider may initial the care plan if a signature page is included in the member's record.
- Completed consent document(s) for release of information.
- A written record of all member-specific care coordination and monitoring activities. The record must include documentation of the following information:
    - The member's name
    - The date of the contact
    - The full name and title of the person who made the contact
    - A clear description of the reason for and nature of the contact
    - The results of the contact
    - The length of time of the contact (the number of minutes or the exact time; e.g., 9:15-10:05 a.m.)
    - Where or how the contact was made
- Referrals and follow up
- All pertinent correspondence relating to coordination of the member's prenatal care

The following are general guidelines for documentation of activities:

- Maintain accurate and legible documentation.
- Correct errors with caution. Do not erase or obliterate errors in established records. Instead, draw a line through the error so the words remain legible. Sign or initial and date the correction.
- Arrange the file in logical order if possible, so that documents can easily be reviewed and audited.
- Ensure that all entries are signed and dated and are in chronological order. Initials are acceptable if the member's file includes a page bearing the provider's full name and signature.
- Keep documentation concise, but descriptive and pertinent. The notation for each entry should be reasonably reflective of the length of time documented for the activity.

  For example, an entry stating, "Called Member X to remind them of their prenatal appointment" should not have a length of time of thirty minutes. A more reasonable notation would state: "Called Member X to remind them of their upcoming prenatal appointment. Answered Member X's questions regarding transportation and child care for their other children. Also provided them with the name and telephone numbers of several child care providers in the area. Made plans with the member for a follow-up home visit."

- If unusual abbreviations and symbols are used routinely (e.g., abbreviations pertaining to internal policy or personal shorthand codes), maintain a key describing each one.

ForwardHealth provides a sample time log form for providers to document activities that were performed.

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 #930

Wisconsin Stats. § 49.46(2)(b)12 and Wis. Admin. Code §§ DHS 105.52 and 107.34 provide the legal framework for PNCC (prenatal care coordination) services.

PNCC was added as a Wisconsin Medicaid benefit as authorized by Act 39, the 1991-93 state budget, as amended by Act 269 Laws of 1991.

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 #931

Outreach

Outreach involves identifying eligible, low-income pregnant women, who may be unaware of or not have access to PNCC (prenatal care coordination) services, and informing them about the benefit. Providers may use a variety of strategies to market and promote PNCC services in the community, such as informational brochures or community presentations.

Providers are not reimbursed separately for outreach activities. Wisconsin Medicaid includes the reimbursement for outreach activities in the reimbursement for the initial assessment.

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.

Topic #1711

Submitting Cost Reports

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

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

- Case management services
- Child/adolescent day treatment
- Community support program services
- Home health services
- Medical day treatment services
- Mental health crisis intervention services
- Outpatient mental health and substance abuse services, including evaluation, psychotherapy, and substance abuse counseling and intensive in-home mental health services for children under HealthCheck
- Outpatient mental health and substance abuse services provided in the home and community (The non-federal share of this service is provided by the county.)
- Personal care services
- PNCC (Prenatal Care Coordination) services
- Substance abuse day treatment

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

Cost Reporting Web Tool

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

- Certification of Medicaid Operating Deficit and Application for Distribution of Federal Financial Participation
- Past WIMCR Cost Reports

- The WIMCR Cost Report Instruction Manual
- Other WIMCR reference documents

Provider Enrollment

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 #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 #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 #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 #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 #927

Requirements

According to Wis. Admin. Code § DHS 106.02(9), all providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation and records. Providers may keep records in written or electronic formats. If providers keep electronic records, they are required to have hard copies available for review and audit.

Wisconsin Admin. Code § DHS 105.52(1), defines the following types of providers and agencies as eligible for Medicaid enrollment as PNCC (prenatal care coordination) providers:

- A community-based health organization
- A community-based social services agency or organization
- A county, city, or combined city and county public health agency
- A county department of human services under Wis. Stats. §§ 46.23, or social services under 46.215 or 46.22
- A family planning agency enrolled under Wis. Admin. Code § DHS 105.36
- An FQHC (federally qualified health center) as defined in 42 CFR 405.2401(b)
- An HMO (health maintenance organization)
- An IPA (Independent Physician Association)
- A hospital
- A physician's office or clinic
- A private case management agency
- An enrolled nurse or nurse practitioner
- An RHC (rural health clinic) enrolled under Wis. Admin. Code § DHS 105.35
- A tribal agency health center
- A WIC (Women, Infants, and Children Supplemental Nutrition Program) program under 42 USC 1786

For Medicaid enrollment as a PNCC service provider, qualified agencies must submit a comprehensive agency outreach and care management plan to Wisconsin Medicaid for approval.

Subcontracting for Prenatal Care Coordination Services

Medicaid-enrolled PNCC providers may subcontract with agencies not enrolled in Wisconsin Medicaid for PNCC services. However, the Medicaid-enrolled provider retains all legal and fiscal responsibility for the services provided by subcontractors.

It is the enrolled provider's responsibility to ensure that the subcontractor provides services and maintains records in accordance with Medicaid requirements for the provision of PNCC services. According to Wis. Admin. Code § DHS 105.02(6)(a), the following records must be maintained:

"Contracts or agreements with persons or organizations for the furnishing of items or services, payment for which may be made in whole or in part, directly or indirectly, by Wisconsin Medicaid."

The Medicaid-enrolled provider is responsible for ensuring that its subcontractors meet all program requirements and receive copies of materials distributed from Wisconsin Medicaid.

Wisconsin Medicaid sends provider materials to Medicaid-enrolled providers only, unless materials are specifically requested by individuals or agencies who are not enrolled in Wisconsin Medicaid.

Although the subcontracted agency may submit claims to Wisconsin Medicaid using the enrolled provider's Medicaid number, Wisconsin Medicaid only reimburses the enrolled provider.

Topic #14317

Terminology to Know for Provider Enrollment

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

New Terminology	Definition
Agent	Any person who has been delegated the authority to obligate or act on behalf of a provider.
Disclosing entity	A Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.
Federal health care programs	Federal health care programs include Medicare, Medicaid, Title XX, and Title XXI.
Other disclosing agent	Any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVII, or XX of the Act. This includes: - Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or HMO that participates in Medicare (Title XVIII) - Any Medicare intermediary or carrier - Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or XX of the Act
Indirect ownership	An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership in the disclosing entity.
Managing employee	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.
Ownership interest	The possession of equity in the capital, the stock, or the profits of the disclosing entity.
Person with an ownership or control interest	A person or corporation for which one or more of the following applies: - Has an ownership interest totaling five percent or more in a disclosing entity - Has an indirect ownership interest equal to five percent or more in a disclosing entity - Has a combination of direct and indirect ownership interest equal to five percent or more in a disclosing entity - Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or asset of the disclosing entity - Is an officer or director of a disclosing entity that is organized as a corporation - Is a person in a disclosing entity that is organized as a partnership
Subcontractor	- An individual, agency, or organization to which a disclosing entity has contracted or delegated some

	of its management functions or responsibilities of providing medical care to its patients; or, • An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.
Re-enrollment	Re-enrollment of a provider whose Medicaid enrollment has ended for any reason other than sanctions or failure to revalidate may be re-enrolled as long as all licensure and enrollment requirements are met. Providers should note that when they re-enroll, application fees and screening activities may apply. Re-enrollment was formerly known as re-instate.
Revalidation	All enrolled providers are required to revalidate their enrollment information every three years to continue their participation with Wisconsin Medicaid. Revalidation was formerly known as recertification.

Note: Providers should note that the federal CMS (Centers for Medicare and Medicaid Services) requires revalidation at least every five years. However, Wisconsin Medicaid will continue to revalidate providers every three years.

Provider Numbers

Topic #3421

Provider Identification

Health Care Providers

Health care providers are required to indicate an NPI (National Provider Identifier) on enrollment applications and electronic and paper transactions submitted to ForwardHealth.

The NPI is a 10-digit number obtained through the NPPES (National Plan and Provider Enumeration System).

Providers should ensure that they have obtained an appropriate NPI prior to beginning their enrollment application. There are two kinds of NPIs:

- Entity Type 1 NPIs are for individuals who provide health care, such as physicians, dentists, and chiropractors.
- Entity Type 2 NPIs are for organizations that provide health care, such as hospitals, group practices, pharmacies, and home health agencies.

It is possible for a provider to qualify for both Entity Type 1 and Entity Type 2 NPIs. For example, an individual physical therapist may also be the owner of a therapy group that is a corporation and have two Wisconsin Medicaid enrollments — one enrollment as an individual physical therapist and the other enrollment as the physical therapy group. A Type 1 NPI for the individual enrollment and a Type 2 NPI for the group enrollment are required.

NPIs and classifications may be viewed on the NPPES website. The federal CMS (Centers for Medicare and Medicaid Services) website includes more information on Type 1 and Type 2 NPIs.

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

Non-healthcare Providers

Non-healthcare providers, such as SMV (specialized medical vehicle) providers, personal care agencies, and blood banks, are exempt from federal NPI requirements. Providers exempt from federal NPI requirements are assigned a Medicaid provider number once their enrollment application is accepted; they are required to indicate this Medicaid provider number on electronic and paper transactions submitted to ForwardHealth.

Topic #5096

Taxonomy Codes

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

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

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

Providers who wish to change their taxonomy code or add additional taxonomy codes may do so using the demographic maintenance tool. Most taxonomy code changes entered through the demographic maintenance tool will take effect in real time; providers may use the new codes immediately on transactions.

Omission of a taxonomy code when it is required as additional data to identify the provider will cause claims and other transactions to be denied or delayed in processing.

Note: Taxonomy codes do not change provider enrollment or affect reimbursement terms.

Topic #5097

ZIP Code

The ZIP code of a provider's practice location address on file with ForwardHealth must be a ZIP+4 code. The ZIP+4 code helps to identify a provider when the NPI (National Provider Identifier) reported to ForwardHealth corresponds to multiple enrollments and the reported taxonomy code does not uniquely identify the provider.

When a ZIP+4 code is required to identify a provider, omission of it will cause claims and other transactions to be denied or delayed in processing.

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

Provider Rights

Topic #208

A Comprehensive Overview of Provider Rights

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

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

Topic #207

Ending Participation

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

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

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

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

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

Wisconsin Medicaid
Provider Enrollment
313 Blettner Blvd
Madison WI 53784

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

Topic #209

Hearing Requests

A provider who wishes to contest a Wisconsin DHS (Department of Health Services) action or inaction for which due process is

required under Wis. Stat. ch. 227, may request a hearing by writing to the DHA (Division of Hearings and Appeals).

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

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

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

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

Topic #210

Limiting the Number of Members

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

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

Topic #206

Requesting Discretionary Waivers and Variances

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

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

Requirements

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

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

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

Application

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

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

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

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

Sanctions

Topic #211

Intermediate Sanctions

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

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

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

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

Topic #212

Involuntary Termination

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

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

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

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

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

Topic #213

Sanctions for Collecting Payment From Members

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

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

Topic #214

Withholding Payments

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

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

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

Reimbursement

7

Archive Date:10/01/2021

Reimbursement:Amounts

Topic #258

Acceptance of Payment

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

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

Topic #694

Billing Service and Clearinghouse Contracts

According to Wis. Admin. Code § DHS 106.03(5)(c)2, contracts with outside billing services or clearinghouses may not be based on commission in which compensation for the service is dependent on reimbursement from BadgerCare Plus. This means compensation must be unrelated, directly or indirectly, to the amount of reimbursement or the number of claims and is not dependent upon the actual collection of payment.

Topic #8117

Electronic Funds Transfer

EFT (electronic funds transfer) allows ForwardHealth to directly deposit payments into a provider's designated bank account for a more efficient delivery of payments than the current process of mailing paper checks. EFT is secure, eliminates paper, and reduces the uncertainty of possible delays in mail delivery.

Only in-state and border-status providers who submit claims and MCOs (managed care organizations) are eligible to receive EFT payments.

Provider Exceptions

EFT payments are not available to the following providers:

- In-state emergency providers
- Out-of-state providers
- Out-of-country providers
- SMV (specialized medical vehicle) providers during their provisional enrollment period

Enrolling in Electronic Funds Transfer

A ForwardHealth Portal account is required to enroll into EFT as all enrollments must be completed via a secure Provider Portal account or a secure MCO Portal account. Paper enrollments are not accepted. A separate EFT enrollment is required for each financial payer a provider bills.

Providers who do not have a Portal account may Request Portal Access online. Providers may also call the Portal Helpdesk for assistance in requesting a Portal account.

The following guidelines apply to EFT enrollment:

- Only a Portal Administrator or a clerk that has been assigned the "EFT" role on the Portal may complete the EFT enrollment information.
- Organizations cannot revert back to receiving paper checks once enrolled in EFT.
- Organizations may change their EFT information at any time.
- Organizations will continue to receive their Remittance Advice as they do currently.

Refer to the Electronic Funds Transfer User Guide on the User Guides page of the Portal for instructions and more information about EFT enrollment.

Providers will continue to receive payment via paper check until the enrollment process moves into "Active" status and the provider's ForwardHealth EFT enrollment is considered complete.

Recoupment and Reversals

Enrollment in EFT does not change the current process of recouping funds. Overpayments and recoupment of funds will continue to be conducted through the reduction of payments.

Note: Enrolling in EFT does not authorize ForwardHealth to make unauthorized debits to the provider's EFT account; however, in some instances an EFT reversal of payment may be necessary. For example, if the system generates a payment twice or the amount entered manually consists of an incorrect value (e.g., a decimal point is omitted creating a $50,000 keyed value for a $500 claim), a reversal will take place to correct the error and resend the correct transaction value. ForwardHealth will notify the designated EFT contact person of an EFT reversal if a payment is made in error due to a system processing or manual data entry error.

Problem Resolution

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

Topic #897

Fee Schedules

Maximum allowable fee information is available on the ForwardHealth Portal in the following forms:

- Interactive fee schedule
- Downloadable fee schedule in TXT (text) files

Certain fee schedules are interactive. Interactive fee schedules provide coverage information as well as maximum allowable fees for all reimbursable procedure codes. The downloadable TXT files are free of charge and provide basic maximum allowable fee information for BadgerCare Plus by provider service area.

A provider may request a paper copy of a fee schedule by calling Provider Services.

Providers may call Provider Services in the following cases:

- Internet access is not available.
- There is uncertainty as to which fee schedule should be used.
- The appropriate fee schedule cannot be found on the Portal.
- To determine coverage or maximum allowable fee of procedure codes not appearing on a fee schedule.

Topic #260

Maximum Allowable Fees

Maximum allowable fees are established for most covered services. Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

Providers are reimbursed at the lesser of their billed amount and the maximum allowable fee for the procedure.

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 #977

Prohibited

Providers are prohibited from collecting copayment for PNCC (prenatal care coordination) services.

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 #253

Payer of Last Resort

Except for a few instances, Wisconsin Medicaid or BadgerCare Plus is the payer of last resort for any covered services. Therefore, the provider is required to make a reasonable effort to exhaust all other existing health insurance sources before submitting claims to ForwardHealth or to a state-contracted MCO (managed care organization).

Topic #255

Primary and Secondary Payers

The terms "primary payer" and "secondary payer" indicate the relative order in which insurance sources are responsible for paying claims.

In general, commercial health insurance is primary to Medicare, and Medicare is primary to Wisconsin Medicaid and BadgerCare Plus. Therefore, Wisconsin Medicaid and BadgerCare Plus are secondary to Medicare, and Medicare is secondary to commercial health insurance.

Reimbursement Not Available

Topic #979

Reimbursement Not Available

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

The following are not reimbursable as PNCC (prenatal care coordination) or CCC (child care coordination) services:

- The provision of diagnostic, treatment, or other direct services, except for health education and nutrition counseling for PNCC providers. Direct services include, but are not limited to, diagnosis of a physical or mental illness and administration of medications.
- Member vocational training.
- Legal advocacy by an attorney or paralegal.
- Ongoing care coordination and monitoring services that are not based on the member's current care plan.
- Ongoing care coordination and monitoring services that are not necessary to meet the CCC or PNCC benefit goal.
- Transportation (provider or member mileage or travel time).
- Interpreter services.
- Missed appointments (no shows).

Topic #695

Reimbursement Not Available Through a Factor

BadgerCare Plus will not reimburse providers through a factor, either directly or by virtue of a power of attorney given to the factor by the provider. A factor is an organization (e.g., a collection agency) or person who advances money to a provider for the purchase or transferal of the provider's accounts receivable. The term "factor" does not include business representatives, such as billing services, clearinghouses, or accounting firms, which render statements and receive payments in the name of the provider.

Topic #51

Services Not Separately Reimbursable

If reimbursement for a service is included in the reimbursement for the primary procedure or service, it is not separately reimbursable. For example, routine venipuncture is not separately reimbursable, but it is included in the reimbursement for the laboratory procedure or the laboratory test preparation and handling fee. Also, DME (durable medical equipment) delivery charges are included in the reimbursement for DME items.

Resources

8

Archive Date:10/01/2021

Resources:Contact Information

Topic #476

Member Services

Providers should refer ForwardHealth members with questions to Member Services. The telephone number for Member Services is for member use only.

Topic #473

Provider Relations Representatives

The Provider Relations representatives, also known as field representatives, conduct training sessions on various ForwardHealth topics for both large and small groups of providers and billers. In addition to provider education, field representatives are available to assist providers with complex billing and claims processing questions. Field representatives are located throughout the state to offer detailed assistance to all ForwardHealth providers and all ForwardHealth programs.

Field Representative Specialization

The field representatives are assigned to specific regions of the state. In addition, the field representatives have specialized in a group of provider types. This specialization allows the field representatives to most efficiently and effectively address provider inquiries. To better direct inquiries, providers should contact the field representative in their region who specializes in their provider type.

Provider Education

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

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

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

Additional Inquiries

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

- Claims, including discrepancies regarding enrollment verification and claim processing
- PES (Provider Electronic Solutions) claims submission software
- Claims processing problems that have not been resolved through other channels (e.g., telephone or written

correspondence)
- Referrals by a Provider Services telephone correspondent
- Complex issues that require extensive explanation

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

If contacting a field representative by email, providers should ensure that no individually identifiable health information, known as PHI (protected health information), is included in the message. PHI can include things such as the member's name combined with their identification number or SSN (Social Security number).

Information to Have Ready

Providers or their representatives should have the following information ready when they call:

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

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

- Member's name
- Member identification number
- Claim number
- DOS (date of service)

Topic #474

Provider Services

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

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

Ways Provider Services Can Help

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

- Billing and claim submissions
- Provider enrollment
- COB (coordination of benefits) (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
- Verifying covered services

Information to Have Ready

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

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

Call Center Correspondent Team

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

Call Center Menu Options and Inquiries

Providers contacting Provider Services are prompted to select from the following menu options:

- Member enrollment—for member enrollment inquiries and verification
- Claim and PA status—for claim and PA status inquiries
- Pharmacy—for drug claim, policy, and drug authorization inquiries
- Dental—for dental inquiries
- Policy—for all policy questions except those for pharmacy and dental
- Provider enrollment—for provider enrollment and revalidation questions
- EHR (Electronic Health Record)—for EHR inquiries

Walk-in Appointments

Walk-in appointments offer face-to-face assistance for providers at the Provider Services office. Providers must schedule an appointment in advance by contacting Provider Services at 800-947-9627. Appointments for in-person provider assistance are available Monday through Friday, 7:30 a.m.-4:00 p.m. (CST), except for state-observed holidays. Providers without an appointment may not receive in-person assistance and may have to schedule an appointment for a later date.

Written Inquiries

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

Providers may submit written inquiries to ForwardHealth by mail using the Written Correspondence Inquiry (F-01170 (07/2012))

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 #475

Provider Suggestions

The DMS (Division of Medicaid Services) is interested in improving its program for providers and members. Providers who would like to suggest a revision of any policy or procedure stated in provider publications or who wish to suggest new policies are encouraged to submit recommendations on the Provider Suggestion (F-01016 (01/2018)) form.

Topic #4456

Resources Reference Guide

The Provider Services and Resources Reference Guide lists services and resources available to providers and members with contact information and hours of availability.

Provider Services and Resources Reference Guide

The Provider Services and Resources Reference Guide lists services and resources available to providers and members with contact information and hours of availability.

ForwardHealth Portal	***www.forwardhealth.wi.gov/***	**24 hours a day, seven days a week**
Public and secure access to ForwardHealth information with direct link to contact Provider Services for up-to-date access to ForwardHealth programs information, including publications, fee schedules, and forms.		
WiCall Automated Voice Response System	**(800) 947-3544**	**24 hours a day, seven days a week**
WiCall, the ForwardHealth Automated Voice Response system, provides responses to the following inquiries: • Checkwrite. • Claim status. • Prior authorization. • Member enrollment.		
ForwardHealth Provider Services Call Center	**(800) 947-9627**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Standard Time)***
To assist providers in the following programs: • BadgerCare Plus. • Medicaid. • SeniorCare. • Wisconsin Well Woman Medicaid. • Wisconsin Chronic Disease Program (WCDP). • Wisconsin Well Woman Program (WWWP). • Wisconsin Medicaid and BadgerCare Plus Managed Care Programs.		
ForwardHealth Portal Helpdesk	**(866) 908-1363**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Standard Time)***
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal accounts, registrations, passwords, and submissions through the Portal.		
Electronic Data Interchange Helpdesk	**(866) 416-4979**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Standard Time)***
For providers, trading partners, billing services, and clearinghouses with technical questions about the following: • Electronic transactions. • Companion documents. • Provider Electronic Solutions (PES) software.		
Managed Care Provider Appeals	**(800) 760-0001, Option 1**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Standard Time)***
To assist BagderCare Plus and Medicaid Supplemental Security Income (SSI) managed care providers with questions regarding their appeal status and other general managed care provider appeal information.		
Managed Care Ombudsman Program	**(800) 760-0001**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Standard Time)***
To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.		
Member Services	**(800) 362-3002**	**Monday through Friday, 8:00 a.m. to 6:00 p.m. (Central Standard Time)***
To assist ForwardHealth members or persons calling on behalf of members with program information and requirements, enrollment, finding certified providers, and resolving concerns.		
Wisconsin AIDS Drug Assistance Program (ADAP)	**(800) 991-5532**	**Monday through Friday, 8:00 a.m. to 4:30 p.m.**

		(Central Standard Time)*
To assist ADAP providers and members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		

*With the exception of state-observed holidays.

Electronic Data Interchange

Topic #459

Companion Guides and NCPDP Version D.0 Payer Sheet

Companion guides and the NCPDP (National Council for Prescription Drug Programs) version D.0 payer sheet are available for download on the ForwardHealth Portal.

Purpose of Companion Guides

ForwardHealth companion guides and payer sheet provide trading partners with useful technical information on ForwardHealth's standards for nationally recognized electronic transactions.

The information in companion guides and payer sheet applies to BadgerCare Plus, Medicaid, SeniorCare, ADAP (Wisconsin AIDS Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program). Companion guides and payer sheet are intended for information technology and systems staff who code billing systems or software.

The companion guides and payer sheet complement the federal HIPAA (Health Insurance Portability and Accountability Act of 1996) implementation guides and highlight information that trading partners need to successfully exchange electronic transactions with ForwardHealth, including general topics such as the following:

- Methods of exchanging electronic information (e.g., exchange interfaces, transaction administration, and data preparation)
- Instructions for constructing the technical component of submitting or receiving electronic transactions (e.g., claims, RA (Remittance Advice), and enrollment inquiries)

Companion guides and payer sheet do **not** include program requirements, but help those who create the electronic formats for electronic data exchange.

Companion guides and payer sheet cover the following specific subjects:

- Getting started (e.g., identification information, testing, and exchange preparation)
- Transaction administration (e.g., tracking claims submissions, contacting the EDI (Electronic Data Interchange) Helpdesk)
- Transaction formats

Revisions to Companion Guides and Payer Sheet

Companion guides and payer sheet may be updated as a result of changes to federal requirements. When this occurs, ForwardHealth will do the following:

- Post the revised companion guides and payer sheet on the ForwardHealth Portal.
- Post a message on the banner page of the RA.
- Send an email to trading partners.

Trading partners are encouraged to periodically check for revised companion guides and payer sheet on the Portal. If trading partners do not follow the revisions identified in the companion guides or payer sheet, transactions may not process successfully (e.g., claims may deny or process incorrectly).

A change summary located at the end of the revised companion guide lists the changes that have been made. The date on the companion guide reflects the date the revised companion guide was posted to the Portal. In addition, the version number located in the footer of the first page is changed with each revision.

Revisions to the payer sheet are listed in Appendix A. The date on the payer sheet reflects the date the revised payer sheet was posted to the Portal.

Topic #460

Data Exchange Methods

The following data exchange methods are supported by the EDI (Electronic Data Interchange) Helpdesk:

- Remote access server dial-up, using a personal computer with a modem, browser, and encryption software
- Secure web, using an internet service provider and a personal computer with a modem, browser, and encryption software
- Real-time, by which trading partners exchange the NCPDP (National Council for Prescription Drug Programs) D.0, 270/271 (270/271 Eligibility & Benefit Inquiry and Response), 276/277 (276/277 Health Care Claim Status Request and Response), or 278 (278 Health Care Services Review — Request for Review and Response) transactions via an approved clearinghouse

The EDI Helpdesk supports the exchange of the transactions for BadgerCare Plus, Medicaid, SeniorCare, ADAP (Wisconsin AIDS Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program).

Topic #461

Electronic Data Interchange Helpdesk

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

Providers with policy questions should call Provider Services.

Topic #462

Electronic Transactions

HIPAA (Health Insurance Portability and Accountability Act of 1996) ASC (Accredited Standards Committee) X12 Version 5010 Companion Guides and the NCPDP (National Council for Prescription Drug Programs) Version D.0 Payer Sheet are available for download on the HIPAA Version 5010 Companion Guides and NCPDP Version D.0 Payer Sheet page of the ForwardHealth Portal.

Trading partners may submit claims and adjustment requests, inquire about member enrollment, claim status, and ForwardHealth payment advice by exchanging electronic transactions.

Through the EDI (Electronic Data Interchange) Helpdesk, trading partners may exchange the following electronic transactions:

- 270/271 (270/271 Eligibility & Benefit Inquiry and Response). The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.

- 276/277 (276/277 Health Care Claim Status Request and Response). The 276 is the electronic transaction for checking claim status. The 277 is received in response.
- 278 (278 Health Care Services Review — Request for Review and Response). The electronic transaction for health care service PA (prior authorization) requests.
- 835 (835 Health Care Claim Payment/Advice). The electronic transaction for receiving remittance information.
- 837 (837 Health Care Claim). The electronic transaction for submitting claims and adjustment requests.
- 999 (999 Acknowledgment for Health Care Insurance). The electronic transaction for reporting whether a transaction is accepted or rejected.
- TA1 interChange Acknowledgment. The electronic transaction for reporting a transaction that is rejected for interChange-level errors.
- NCPDP D.0 Telecommunication Standard for Retail Pharmacy claims. The real-time POS (Point-of-Sale) electronic transaction for submitting pharmacy claims.

Topic #463

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. PES (Provider Electronic Solutions) software allows providers to submit 837 (837 Health Care Claim) transactions and download the 999 (999 Acknowledgment for Health Care Insurance) and the 835 (835 Health Care Claim Payment/Advice) transactions. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Topic #464

Trading Partner Profile

A Trading Partner Profile must be completed and signed for each billing provider number that will be used to exchange electronic transactions.

In addition, billing providers who do not use a third party to exchange electronic transactions, billing services, and clearinghouses are required to complete a Trading Partner Profile.

To determine whether a Trading Partner Profile is required, providers should refer to the following:

- Billing providers who do not use a third party to exchange electronic transactions, including providers who use the PES (Provider Electronic Solutions) software, are required to complete the Trading Partner Profile.
- Billing providers who use a third party (billing services and clearinghouses) to exchange electronic transactions are required to submit a Trading Partner Profile.
- Billing services and clearinghouses, including those that use PES software, that are authorized by providers to exchange electronic transactions on a provider's behalf, are required to submit a Trading Partner Profile.

Providers who change billing services and clearinghouses or become a trading partner should keep their information updated by contacting the EDI (Electronic Data Interchange) Helpdesk.

Topic #465

Trading Partners

ForwardHealth exchanges nationally recognized electronic transactions with trading partners. A "trading partner" is defined as a

covered entity that exchanges electronic health care transactions. The following covered entities are considered trading partners:

- Providers who exchange electronic transactions directly with ForwardHealth
- Billing services and clearinghouses that exchange electronic transactions directly with ForwardHealth on behalf of a billing provider

Enrollment Verification

Topic #256

270/271 Transactions

The 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response) transactions allow for batch enrollment verification, including information for the current benefit month or for any date of eligibility the member has on file, through a secure internet connection. The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.

For those providers who are federally required to have an NPI (National Provider Identifier), an NPI is required on the 270/271 transactions. The NPI indicated on the 270 is verified to ensure it is associated with a valid enrollment on file with ForwardHealth. The 271 response will report the NPI that was indicated on the 270.

For those providers exempt from NPI, a provider ID is required on the 270/271 transactions. The provider ID indicated on the 270 is verified to ensure it is associated with a valid enrollment on file with ForwardHealth. The 271 response will report the provider ID that was indicated on the 270.

Topic #469

An Overview

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

- A member's enrollment in a ForwardHealth program(s)
- State-contracted MCO (managed care organization) enrollment
- Medicare enrollment
- Limited benefits categories
- Any other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) coverage
- Exemption from copayments for BadgerCare Plus members

Topic #259

Commercial Enrollment Verification Vendors

ForwardHealth has agreements with several commercial enrollment verification vendors to offer enrollment verification technology to ForwardHealth providers. Commercial enrollment verification vendors have up-to-date access to the ForwardHealth enrollment files to ensure that providers have access to the most current enrollment information. Providers may access Wisconsin's EVS (Enrollment Verification System) to verify member enrollment through one or more of the following methods available from commercial enrollment verification vendors:

- Magnetic stripe card readers
- Personal computer software
- Internet

Vendors sell magnetic stripe card readers, personal computer software, internet access, and other services. They also provide ongoing maintenance, operations, and upgrades of their systems. Providers are responsible for the costs of using these enrollment verification methods.

Note: Providers are *not* required to purchase services from a commercial enrollment verification vendor. For more information on other ways to verify member enrollment or for questions about ForwardHealth identification cards, contact Provider Services.

The real-time enrollment verification methods allow providers to print a paper copy of the member's enrollment information, including a transaction number, for their records. Providers should retain this number or the printout as proof that an inquiry was made.

Magnetic Stripe Card Readers

The magnetic stripe card readers resemble credit card readers. Some ForwardHealth identification cards have a magnetic stripe and signature panel on the back, and a unique, 16-digit card number on the front. The 16-digit card number is valid only for use with a magnetic card reader.

Providers receive current member enrollment information after passing the ForwardHealth card through the reader or entering the member identification number or card number into a keypad and entering the DOS (date of service) about which they are inquiring.

Personal Computer Software

Personal computer software can be integrated into a provider's current computer system by using a modem and can access the same information as the magnetic stripe card readers.

Internet Access

Some enrollment verification vendors provide real-time access to enrollment from the EVS through the internet.

Topic #4903

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.

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 #982

Division of Medicaid Services Publications

The following CCC (child care coordination) and PNCC (prenatal care coordination) publications are available from DMS (Division of Medicaid Services) at the address listed below. There is no charge for these publications.

- Child Care Coordination Family Questionnaire (F-01118 (03/2016)) (F-01118)
- Prenatal Care Coordination Pregnancy Questionnaire (F-01105 (02/2009)) (Risk Assessment Form) (F-01105)
- Guidance Manual for the Pregnancy Questionnaire (POH 1043)
- HealthCheck Brochure (Spanish) (POH 1007S)
- HealthCheck Brochure (Hmong) (POH 1007H)
- HealthCheck Brochure (English) (POH 1007)
- HealthCheck Poster (8 1/2 x 14) (POH 1041)
- HealthCheck Stuffer/Handbill (POH 1041A)
- HealthCheck Stickers (POH 1041C)

The forms are available from the following address:

Division of Medicaid Services
Bureau of Benefits Management
Attn: Forms Manager
PO Box 309
Madison WI 53701-0309

Division of Public Health Publications

The following CCC and PNCC publications are available from the DHS (Department of Health Services) Forms Center. There is minimal or no charge for the following documents.

- Family Health Resource Catalog (a list of maternal and child health education materials) (PPH 4536)
- If I'm Pregnant, Can the Chemicals I Work with Harm my Baby? (DPH 7074)
- Child Growth Grid - Boy (DOH 4517)
- Child Growth Grid - Girl (DOH 4518)
- Prenatal Weight Gain Grid (DOH 4056)
- Planning a Healthy Pregnancy: Self Care Handbook (PPH 9322)
- Planning a Healthy Pregnancy: Self Care Handbook (Spanish) (PPH 9322-S)
- Caring for Your Baby: A Newborn and Infant Care Handbook (PPH 9321)
- Caring for Your Baby: A Newborn and Infant Care Handbook (Spanish) (PPH 9321-S)

The forms are available from the following address:

Department of Health Services Forms Center
PO Box 7850
Madison WI 53701-7850

Children's Trust Fund

The following information is available from the Children's Trust Fund:

- Information on child abuse and neglect
- Positive Parenting Kit

Providers may call the Children's Trust Fund at 866-640-3936, or write to the following address:

110 E. Main St
Ste 614
Madison WI 53703

Topic #470

Fillable Forms

Most forms may be obtained from the Forms page of the ForwardHealth Portal.

Forms on the Portal are available as fillable PDF (Portable Document Format) files, which can be viewed with Adobe Reader computer software. Providers may also complete and print fillable PDF files using Adobe Reader.

To complete a fillable PDF, follow these steps:

- Select a specific form.
- Save the form to the computer.
- Use the "Tab" key to move from field to field.

Note: The Portal provides instructions on how to obtain Adobe Reader at no charge from the Adobe website. Adobe Reader only allows providers to view and print completed PDFs. It does not allow users to save completed fillable PDFs to their computer; however, if Adobe Acrobat is purchased, providers may save completed PDFs to their computer. Refer to the Adobe website for more information about fillable PDFs.

Selected forms are also available in fillable Microsoft Word format on the Portal. The fillable Microsoft Word format allows providers to complete and print the form using Microsoft Word. To complete a fillable Microsoft Word form, follow these steps:

- Select a specific form.
- Save the form to the computer.
- Use the "Tab" key to move from field to field.

Note: Providers may save fillable Microsoft Word documents to their computer by choosing "Save As" from the "File" menu, creating a file name, and selecting "Save" on their desktop.

Topic #766

Telephone or Mail Requests

Providers who do not have internet access or who need forms that are not available on the ForwardHealth Portal may obtain them by doing either of the following:

- Requesting a paper copy of the form by calling Provider Services. Questions about forms may also be directed to Provider Services.
- Submitting a written request and mailing it to ForwardHealth. Include a return address, the name of the form, and the form number and send the request to the following address:

  ForwardHealth
  Form Reorder
  313 Blettner Blvd
  Madison WI 53784

Portal

Topic #4904

Claims and Adjustments Using the ForwardHealth Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, copy claims, and determine what claims are in "pay" status on the ForwardHealth Portal. Providers have the ability to search for and view the status of all their finalized claims, regardless of how they were submitted (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim through DDE (Direct Data Entry) through the secure Portal.

Topic #8524

Conducting Revalidation Via the ForwardHealth Portal

Providers can conduct revalidation online via a secure revalidation area of the ForwardHealth Portal.

Topic #5157

Cost Share Reports for Long-Term Managed Care Organizations

Individual cost share reports for long-term care MCOs (managed care organizations) that provide Family Care, Family Care Partnership, and PACE (Program of All-Inclusive Care for the Elderly) services are available via the secure area of the ForwardHealth Portal and can be downloaded as an Excel file.

Topic #4345

Creating a Provider Account

Each provider needs to designate one individual as an administrator of the ForwardHealth Portal account. This user establishes the administrative account once their PIN (personal identification number) is received. The administrative user is responsible for this provider account and is able to add accounts for other users (clerks) within their organization and assign security roles to clerks that have been established. To establish an administrative account after receiving a PIN, the administrative user is required to follow these steps:

1. Go to the ForwardHealth Portal.
2. Click the **Providers** button.
3. Click **Logging in for the first time?**.
4. Enter the Login ID and PIN. The Login ID is the provider's NPI (National Provider Identifier) or provider number.
5. Click **Setup Account**.

6. At the Account Setup screen, enter the user's information in the required fields.
7. Read the security agreement and click the checkbox to indicate agreement with its contents.
8. Click **Submit** when complete.

Once in the secure Provider area of the Portal, the provider may conduct business online with ForwardHealth via a secure connection. Providers may also perform the following administrative functions from the Provider area of the Portal:

- Establish accounts and define access levels for clerks
- Add other organizations to the account
- Switch organizations

Refer to the Account User Guide on the User Guides page of the Portal for more detailed instructions on performing these functions.

Topic #16737

Demographic Maintenance Tool

The demographic maintenance tool allows providers to update information online that they are required to keep current with ForwardHealth. To access the demographic maintenance tool, providers need a ForwardHealth Portal account. After logging into their Portal account, providers should select the Demographic Maintenance link located in the Home Page box on the right side of the secure Provider home page.

Note: The Demographic Maintenance link will only display for administrative accounts or for clerk accounts that have been assigned the Demographic Maintenance role. The Account User Guide provides specific information about assigning roles.

The demographic maintenance tool contains general panels which are available to all or most providers as well as specific panels which are only available to certain provider types and specialties. The Demographic Maintenance Tool User Guide provides further information about general and provider-specific panels.

Uploading Supporting Documentation

Providers can upload enrollment-related supporting documentation (e.g., licenses, certifications) using the demographic maintenance tool. Documents in the following formats can be uploaded:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg)
- PDF (Portable Document Format) (.pdf)

To avoid delays in processing, ForwardHealth strongly encourages providers to upload their documents.

Submitting Information

After making **all** their changes, providers are required to submit their information in order to save it. After submitting information, providers will receive one of the following messages:

- "Your information was **updated** successfully." This message indicates that providers' files were immediately updated with the changed information.
- "Your information was **uploaded** successfully." This message indicates that ForwardHealth needs to verify the information before providers' files can be updated. Additionally, an Application Submitted panel will display and indicate next steps.

Verification

ForwardHealth will verify changes within 10 business days of submission. If the changes can be verified, ForwardHealth will update providers' files. In some cases, providers may receive a Change Notification letter indicating what information ForwardHealth updated. Providers should carefully review the Provider File Information Change Summary included with the letter to verify the accuracy of the changes. If any of the changes are inaccurate, providers can correct the information using the demographic maintenance tool. Providers may contact Provider Services if they have questions regarding the letter.

Regardless of whether or not providers are notified that their provider files were updated, changed information is not considered approved until 10 business days after the information was changed. If the changes cannot be verified within 10 business days, ForwardHealth will notify providers by mail that their provider files were not updated, and providers will need to make corrections using the demographic maintenance tool.

Topic #4340

Designating a Trading Partner to Receive 835 Health Care Claim Payment/Advice Transactions

Providers must designate a trading partner to receive their 835 (835 Health Care Claim Payment/Advice) transaction for ForwardHealth interChange.

Providers who wish to submit their 835 designation via the Portal are required to create and establish a provider account to have access to the secure area of the Portal.

To designate a trading partner to receive 835 transactions, providers must first complete the following steps:

1. Access the Portal and log into their secure account by clicking the Provider link/button.
2. Click on the Designate 835 Receiver link on the right-hand side of the secure home page.
3. Enter the identification number of the trading partner that is to receive the 835 in the Trading Partner ID field.
4. Click Save.

Providers who are unable to use the Portal to designate a trading partner to receive 835 transactions may call the EDI (Electronic Data Interchange) Helpdesk or submit a paper (Trading Partner 835 Designation, F-13393 (07/12)) form.

Topic #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.

Topic #4743

Managed Care Organization Portal

Information and Functions Through the Portal

The MCO (managed care organization) area of the ForwardHealth Portal allows state-contracted MCOs to conduct business with ForwardHealth. The public MCO page offers easy access to key MCO information and web tools. A login is required to access the secure area of the Portal to submit or retrieve account and member information that may be sensitive.

The following information is available through the Portal:

- Listing of all Medicaid-enrolled providers
- Coordination of Benefits Extract/Insurance Carrier Master List information updated quarterly
- Data Warehouse, which is linked from the Portal to Business Objects. The Business Objects function allows for access to MCO data for long-term care MCOs.
- Electronic messages
- Enrollment verification by entering a member ID or SSN (Social Security number) with date of birth and a "from DOS (date of service)" and a "to DOS" range. A transaction number is assigned to track the request.
- Member search function for retrieving member information such as medical status codes and managed care and Medicare information
- Provider search function for retrieving provider information such as the address, telephone number, provider ID, taxonomy code (if applicable), and provider type and specialty
- HealthCheck information
- MCO contact information
- Technical contact information (Entries may be added via the Portal.)

Topic #5158

Managed Care Organization Portal Reports

The following reports are generated to MCOs (managed care organizations) through their account on the ForwardHealth MCO Portal:

- Capitation Payment Listing Report
- Cost Share Report (long-term MCOs only)
- Enrollment Reports

MCOs are required to establish a Portal account in order to receive reports from ForwardHealth.

Capitation Payment Listing Report

The Capitation Payment Listing Report provides "payee" MCOs with a detailed listing of the members for whom they receive capitation payments. ForwardHealth interChange creates adjustment transaction information weekly and regular capitation transaction information monthly. The weekly batch report includes regular and adjustment capitation transactions. MCOs have the option of receiving both the Capitation Payment Listing Report and the 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transactions.

Initial Enrollment Roster Report

The Initial Enrollment Roster Report is generated according to the annual schedules detailing the number of new and continuing members enrolled in the MCO and those disenrolled before the next enrollment month.

Final Enrollment Roster Report

The Final Enrollment Roster Report is generated the last business day of each month and includes members who have had a change in status since the initial report and new members who were enrolled after the Initial Enrollment Roster Report was generated.

Other Reports

Additional reports are available for BadgerCare Plus HMOs, SSI HMOs, and long-term MCOs. Some are available via the Portal and some in the secure FTP (file transfer protocol).

Topic #4744

Members ForwardHealth Portal

Members can access ForwardHealth information by going to the ForwardHealth Portal. Members can search through a directory of providers by entering a ZIP code, city, or county. Members can also access all member-related ForwardHealth applications and forms. Members can use ACCESS to check availability, apply for benefits, check current benefits, and report any changes.

Topic #4344

Obtaining a Personal Identification Number

To establish an account on the ForwardHealth Portal, providers are required to obtain a PIN (personal identification number). The PIN is a unique, nine-digit number assigned by ForwardHealth interChange for the sole purpose of allowing a provider to establish a Portal account. It is used in conjunction with the provider's login ID. Once the Portal account is established, the provider will be prompted to create a username and password for the account, which will subsequently be used to log in to the Portal.

Note: The PIN used to create the provider's Portal account is not the same PIN used for revalidation. Providers will receive a separate PIN for revalidation.

A provider may need to request more than one PIN if he or she is a provider for more than one program or has more than one type of provider enrollment. A separate PIN will be needed for each provider enrollment. Health care providers will need to supply their NPI (National Provider Identifier) and corresponding taxonomy code when requesting an account. Non-healthcare providers will need to supply their unique provider number.

Providers may request a PIN by following these steps:

1. Go to the Portal.
2. Click on the "Providers" link or button.
3. Click the "Request Portal Access" link from the Quick Links box on the right side of the screen.
4. At the Request Portal Access screen, enter the following information:
    a. Health care providers are required to enter their NPI and click "Search" to display a listing of ForwardHealth enrollments. Select the correct enrollment for the account. The taxonomy code, ZIP+4 code, and financial payer for that enrollment will be automatically populated. Enter the SSN (Social Security number) or TIN (Tax Identification Number).
    b. Non-healthcare providers are required to enter their provider number, financial payer, and SSN or TIN. (This option should only be used by non-healthcare providers who are exempt from NPI requirements).

       The financial payer is one of the following:
        - Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and Senior Care.)
        - SSI (Supplemental Security Income)
        - WCDP (Wisconsin Chronic Disease Program)
        - The WWWP (Wisconsin Well Woman Program)

    c. Click **Submit**.
    d. Once the Portal Access Request is successfully completed, ForwardHealth will send a letter with the provider's PIN to the address on file.

Topic #4459

Online Handbook

The Online Handbook gives providers access to all policy and billing information for Wisconsin Medicaid, BadgerCare Plus, ADAP (Wisconsin AIDS Drug Assistance Program), and WCDP (Wisconsin Chronic Disease Program). A secure ForwardHealth Portal account is not required to use the Online Handbook, as it is available to all Portal visitors.

Revisions to Online Handbook information are incorporated after policy changes have been issued in *ForwardHealth Updates*, typically on the policy effective date. The Online Handbook also links to the Communication Home page, which takes users to ForwardHealth Updates, user guides, and other communication pages.

The Online Handbook is designed to sort information based on user-entered criteria, such as program and provider type. It is organized into sections, 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.

Topic #4912

Portal Clerk Administrators

A Portal administrator may choose to delegate some of the authority and responsibility for setting up and managing the users within their ForwardHealth Portal account. If so, the Portal administrator may establish a clerk administrator. An administrator or clerk administrator can create, modify, manage or remove clerks for a Portal account. When a clerk is created, the administrator or clerk administrator must grant permissions to the clerks to ensure they have the appropriate access to the functions they will perform. A clerk administrator can only grant permissions that they themselves have. For example, if an administrator gives a clerk administrator permission only for enrollment verification, then the clerk administrator can only establish clerks with enrollment verification permissions.

Even if a Portal administrator chooses to create a clerk administrator and delegate the ability to add, modify, and remove users from the same account, the Portal administrator is still responsible for ensuring the integrity and security of the Portal account.

Topic #4913

Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their ForwardHealth Portal account. Clerks may be assigned one or many roles (i.e., claims, PA (prior authorization), member enrollment verification). Clerks do not have the ability to establish, modify, or remove other accounts.

Once a clerk account is set up, the clerk account does not have to be established again for a separate Portal account. Clerks can easily be assigned a role for different Portal accounts (i.e., different ForwardHealth enrollments). To perform work under a different Portal account for which they have been granted authorization, a clerk can use the "switch org" function and toggle between the Portal accounts to which they have access. Clerks may be granted different authorization in each Portal account (i.e., they may do member enrollment verification for one Portal account, and HealthCheck inquires for another).

Topic #4740

Public Area of the Provider Portal

The public Provider area of the ForwardHealth Portal offers a variety of important business features and functions that will assist in daily business activities with ForwardHealth programs.

Maximum Allowable Fee Schedules

Within the Portal, all maximum allowable fee schedules for Medicaid, BadgerCare Plus, and WCDP (Wisconsin Chronic Disease Program) are interactive and searchable. Providers can enter the DOS (date of service), along with other information such as procedure code, category of supplies, or provider type, to find the maximum allowable fee. Providers can also download all fee schedules.

ForwardHealth Communications

ForwardHealth Updates announce changes in policy and coverage, PA (prior authorization) requirements, and claim submission requirements. They communicate new initiatives from the Wisconsin DHS (Department of Health Services) or new requirements from the federal CMS (Centers for Medicare and Medicaid Services) and the Wisconsin state legislature.

Updates reflect current policy at the time of publication; this information may change over time and be revised by a subsequent *Update*. *Update* information is added to the ForwardHealth Online Handbook after the *Update* is posted, unless otherwise noted.

Providers should refer to the Online Handbook for current information. The Online Handbook is the source for current ForwardHealth policy and contains provider-specific information for various services and benefits.

Training

Providers can register for all scheduled trainings and view online trainings via the Training page, which contains an up-to-date calendar of all available training. Additionally, providers can view webcasts of select trainings.

Contacting Provider Services

Providers and other Portal users will have an additional option for contacting Provider Services through the Contact link on the Portal. Providers can enter the relevant inquiry information, including selecting the preferred method of response (i.e., telephone call or email) the provider wishes to receive back from Provider Services. Provider Services will respond to the inquiry within five business days. Information will be submitted via a secure connection.

Online Enrollment

Providers can speed up the enrollment process for Medicaid by completing a provider enrollment application via the Portal. Providers can then track their application by entering their ATN (application tracking number) given to them on completion of the application.

Other Resources Available on the Portal

The public Provider area of the Portal also includes the following features:

- A "What's New?" section for providers that links to the latest information posted to the Provider area of the Portal.
- Home page for the provider. Providers have administrative control over their Portal homepage and can grant other employees access to specified areas of the Portal, such as claims and PA (prior authorization).
- Email subscription service for *Updates*. Providers can register for email subscription to receive notifications of new provider publications via email. Users are able to select, by program and service area, which publication notifications they would like to receive.
- A forms library.

Topic #4741

Secure Area of the Provider Portal

Providers can accomplish many processes via the ForwardHealth Portal, including submitting, adjusting, and correcting claims, submitting and amending PA (prior authorization) requests, and verifying enrollment.

Claims and Adjustments Using the Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, and determine what claims are in "pay" status on the Portal. Providers 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	Microsoft Internet Explorer v. 6.0 or higher, or Firefox v. 1.5 or higher
Windows XP or higher operating system	
Apple-Based Systems	
Computer running a PowerPC G4 or Intel processor, 512 MB of RAM, and 150MB of free disk space	Safari, or Firefox v. 1.5 or higher
Mac OS X 10.2.x or higher operating system	

Topic #4742

Trading Partner Portal

The following information is available on the public Trading Partners area of the ForwardHealth Portal:

- Trading partner testing packets
- Trading partner profile submission
- PES (Provider Electronic Solutions) software and upgrade information
- EDI (Electronic Data Interchange) companion guides

In the secure Trading Partners area of the Portal, trading partners can exchange electronic transactions with ForwardHealth.

Trading partners using PES should be sure to enter the web logon and web password associated with the ForwardHealth Trading Partner ID that will be used on PES transactions. Prior to submitting transactions through PES, trading partners must also make sure their trading partner account is entered as the "Default Provider ID" on the Switch Organization page of the secure trading partner account on the Portal.

Training Opportunities

Topic #12757

Training Opportunities

The Provider Relations representatives conduct training sessions in a variety of formats on both program-specific and topic-specific subjects. There is no fee for attending/accessing these training sessions.

On-Site Sessions

On-site training sessions are offered at various locations (e.g., hotel conference rooms, provider facilities) throughout the state. These training sessions include general all-provider sessions, service-specific and/or topic-specific sessions, and program-specific (such as WCDP (Wisconsin Chronic Disease Program) or the WWWP (Wisconsin Well Woman Program)) sessions.

Registration is required to attend on-site sessions. Online registration is available on the Trainings page of the Providers area of the Portal.

Online (Real-Time, Web-Based) Sessions

Online (real-time, web-based) training sessions are available and are facilitated through HPE MyRoom. MyRoom sessions are offered on many of the same topics as on-site sessions, but online sessions offer the following advantages:

- Participants can attend training at their own computers without leaving the office.
- Sessions are interactive as participants can ask questions during the session.
- If requested or needed, a session can be quickly organized to cover a specific topic for a small group or office.

For some larger training topics (such as ForwardHealth Portal Fundamentals), the training may be divided into individual modules, with each module focused on a particular subject. This allows participants to customize their training experience.

Registration, including an e-mail address, is required to attend Virtual Room sessions, so important session information can be sent to participants prior to the start of the session. Online registration is available on the Trainings page of the Portal.

Recorded Webcasts

Recorded Webcasts are available on a variety of topics, including some of the same topics as on-site and online sessions. Like Virtual Room sessions, some recorded Webcasts on larger training topics may be divided into individual Webcast modules, allowing participants to customize their training experience. Recorded Webcasts allow providers to view the training at their convenience on their own computers.

Registration is not required to view a recorded Webcast. Related training materials are available to download and print from the specific Webcast training session page on the Portal.

Notification of Training Opportunities

In addition to information on the Trainings page of the Portal, upcoming training session information is distributed directly through messages to providers who have secure Portal accounts and to providers who have registered for the ForwardHealth e-mail subscription service.

To sign up for a secure Portal account, click the "Request Portal Access" link in the Quick Links box on the Provider page of the Portal. To sign up for e-mail subscription, click "Register for E-mail Subscription" in the Quick Links box on the Provider page of the Portal.

Updates

Topic #478

Accessing ForwardHealth Communications

ForwardHealth Updates announce changes in policy and coverage, prior authorization requirements, and claim submission requirements. They communicate new initiatives from the Wisconsin Department of Health Services or new requirements from the federal Centers for Medicare and Medicaid Services and the Wisconsin state legislature.

Updates reflect current policy at the time of publication; this information may change over time and be revised by a subsequent *Update*. *Update* information is added to the Online Handbook after the *Update* is posted, unless otherwise noted.

Providers should refer to the *ForwardHealth Online Handbook* for current information. The Online Handbook is the source for current ForwardHealth policy and contains provider-specific information for various services and benefits.

Topic #4458

Electronic Notifications from ForwardHealth

ForwardHealth sends electronic messaging 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.

WiCall

Topic #257

Enrollment Inquiries

WiCall is an AVR (Automated Voice Response) system that allows providers with touch-tone telephones direct access to enrollment information.

Information from WiCall will be returned in the following order if applicable to the member's current enrollment:

- Transaction number: A number will be given as a transaction confirmation that providers should keep for their records.
- Benefit enrollment: All benefit plans the member is enrolled in on the DOS (date of service) or within the DOS range selected for the financial payer.
- County code: The member's county code will be provided if available. The county code is a two-digit code between 01 and 72 that represents the county in which member resides. If the enrollment response reflects that the member resides in a designated HPSA (Health Personnel Shortage Area) on the DOS or within the DOS range selected, HPSA information will be given.
- MCO (managed care organization): All information about state-contracted MCO enrollment, including MCO names and telephone numbers, that exists on the DOS or within the DOS range selected will be listed. This information is applicable to Medicaid and BadgerCare Plus members only.
- Hospice: If the member is enrolled in the hospice benefit on the DOS or within the DOS range that the provider selected, the hospice information will be given. This information is applicable to Medicaid and BadgerCare Plus members only.
- Lock-in: Information about the Pharmacy Services Lock-In Program that exists on the DOS or within the DOS range selected will be provided. This information is applicable to Medicaid, BadgerCare Plus, and SeniorCare members only.
- Medicare: All information about Medicare coverage, including type of coverage and Medicare member ID, if available, that exists on the DOS or within the DOS range selected will be listed.
- Commercial health insurance coverage: All information about commercial coverage, including carrier names and telephone numbers, if available, that exists on the DOS or within the DOS range selected will be listed.
- Transaction completed: After the member's enrollment information has been given using the financial payer that was selected, providers will be given the following options to:
  - Hear the information again
  - Request enrollment information for the same member using a different financial payer
  - Hear another member's enrollment information using the same financial payer
  - Hear another member's enrollment information using a different financial payer
  - Return to the main menu

WiCall is available 24 hours a day, seven days a week. If for some reason the system is unavailable, providers may call Provider Services.

Transaction Number

The AVR system issues a transaction number every time a provider verifies enrollment, even when an individual is *not* enrolled in BadgerCare Plus or Wisconsin Medicaid. The provider should retain this transaction number. It is proof that an inquiry was made about the member's enrollment. If a provider thinks a claim was denied in error, the provider can reference the transaction number to ForwardHealth to confirm the enrollment response that was actually given.

Topic #6257

Entering Letters into WiCall

For some WiCall inquries, health care providers are required to enter their taxonomy code with their NPI (National Provider Identifier). Because taxonomy codes are a combination of numbers and letters, telephone key pad combinations, shown in the table below, allow providers to successfully enter taxonomy code letters for WiCall functions (e.g., press *21 to enter an "A," press *72 to enter an "R").

Letter	Key Combination	Letter	Key Combination
A	*21	N	*62
B	*22	O	*63
C	*23	P	*71
D	*31	Q	*11
E	*32	R	*72
F	*33	S	*73
G	*41	T	*81
H	*42	U	*82
I	*43	V	*83
J	*51	W	*91
K	*52	X	*92
L	*53	Y	*93
M	*61	Z	*12

Additionally, providers may select option 9 and press "#" for an automated voice explanation of how to enter letters in WiCall.

Topic #466

Information Available Via WiCall

WiCall, ForwardHealth's AVR (Automated Voice Response) system, gathers inquiry information from callers through voice prompts and accesses ForwardHealth interChange to retrieve and "speak" back the following ForwardHealth information:

- Claim status
- Enrollment verification
- PA (prior authorization) status
- Provider CheckWrite information

Note: ForwardHealth releases CheckWrite information to WiCall no sooner than on the first state business day following the financial cycle.

Providers are prompted to enter NPI (National Provider Identifier) or provider ID and in some cases, NPI-related data, to retrieve query information.

In all inquiry scenarios, WiCall offers the following options after information is retrieved and reported back to the caller:

- Repeat the information.
- Make another inquiry of the same type.
- Return to the main menu.
- Repeat the options.

Claim Status

Providers may check the status of a specific claim by selecting the applicable financial payer (program, i.e., Wisconsin Medicaid, WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)) and entering their provider ID, member identification number, DOS (date of service), and the amount billed.

Note: Claim information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Enrollment Verification

Providers may request enrollment status for any date of eligibility the member has on file by entering their provider ID and the member ID. If the member ID is unknown, providers may enter the member's date of birth and SSN (Social Security number). Additionally, the provider is prompted to enter the "From DOS" and the "To DOS" for the inquiry. The "From" DOS is the earliest date the provider requires enrollment information and the "To" DOS must be within 365 days of the "From" DOS.

Each time a provider verifies member enrollment, the enrollment verification is saved and assigned a transaction number as transaction confirmation. Providers should note the transaction number for their records.

PA Status

Except in certain instances, providers may obtain the status of PA requests for Medicaid and WCDP via WiCall by entering their provider ID and the applicable PA number. If the provider does not know the PA number, there is an option to bypass entering the PA number and the caller will be prompted to enter other PA information such as member ID and type of service (i.e., NDC (National Drug Code), procedure code, revenue code, or ICD (International Classification of Diseases) procedure code). When a match is found, WiCall reports back the PA status information, including the PA number for future reference, and the applicable program.

Information on past PAs is retained indefinitely. Paper PAs require a maximum of 20 working days from receipt to be processed and incorporated into WiCall's PA status information.

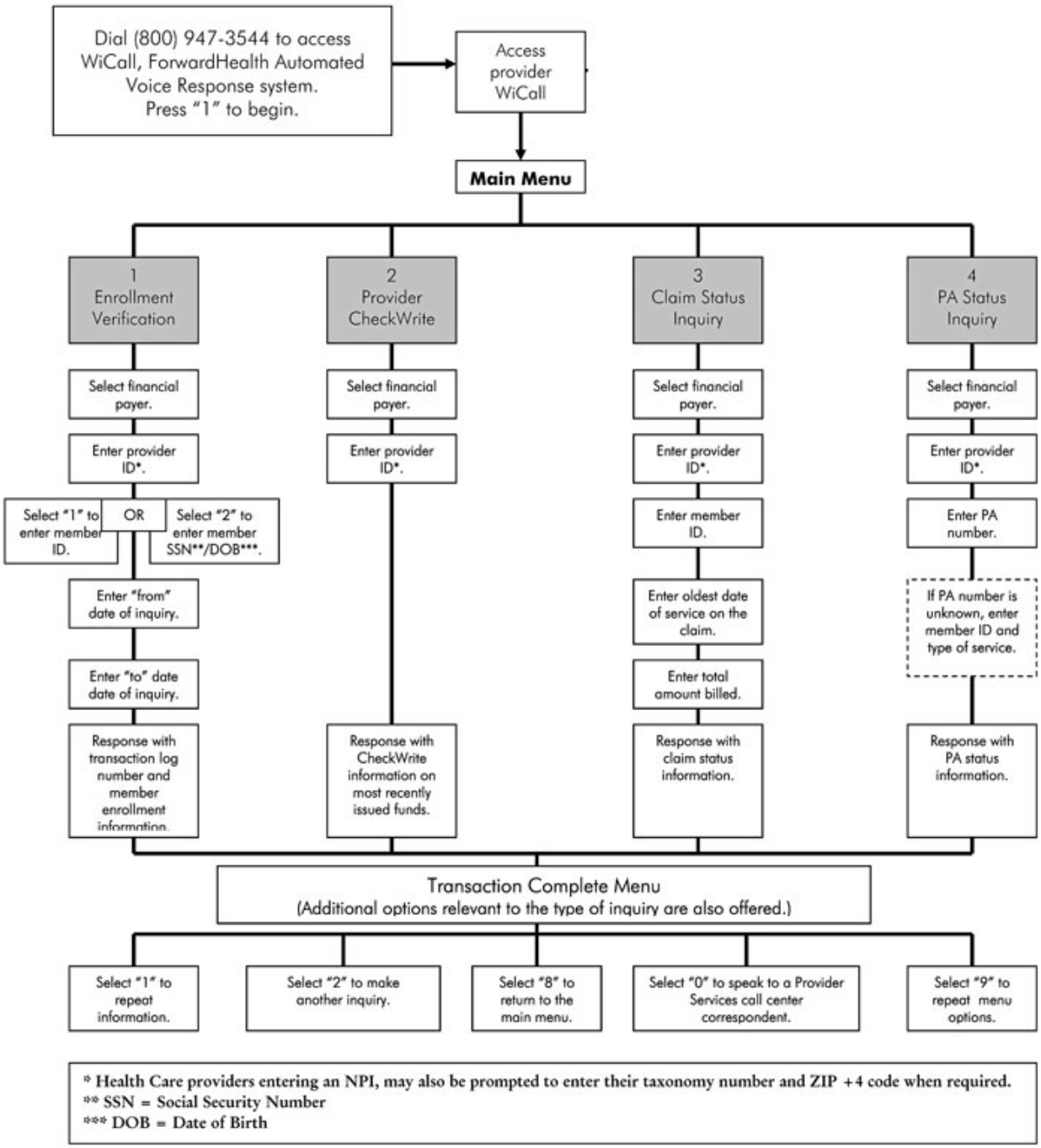
Note: PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Topic #765

Quick Reference Guide

The WiCall AVR (Automated Voice Response) Quick Reference Guide displays the information available for WiCall inquiries.

Automated Voice Response Quick Reference Guide



* Health Care providers entering an NPI, may also be prompted to enter their taxonomy number and ZIP +4 code when required.
** SSN = Social Security Number
*** DOB = Date of Birth