

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 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 found, the provider can alter the claim to reflect the desired change and resubmit it to ForwardHealth. Any claim ForwardHealth has paid can be adjusted and resubmitted on the Portal, regardless of how the claim was originally submitted.

Topic #513

Follow-Up

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

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

Topic #515

Paper

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

Topic #816

Processing

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

Topic #514

Purpose

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

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

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

Topic #645

Examples of When to Submit Adjustment Requests

Examples of when physician services providers may submit an adjustment request include, but are not limited to, the following:

- Critical care and prolonged services lasting longer than six hours.
- Emergency room services with unique circumstances or unusually high complexity.
- Obstetrical services with an unusually high number of antepartum or postpartum care visits or complications.

Topic #4857

Submitting Paper Attachments with Electronic Claim Adjustments

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

Good Faith Claims

Topic #518

Definition

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

Overpayments

Topic #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 [DHS 106.08](#), Wis. Admin. Code.
- Claiming and receiving ForwardHealth reimbursement in sufficient amounts to allow the recovery of the overpayment within a very limited period of time. The period of time is usually no more than 60 days.

Electronic Adjustment Requests

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

Paper Adjustment Requests

For [paper adjustment requests](#), providers are required to do the following:

- Submit an [Adjustment/Reconsideration Request \(F-13046 \(07/12\)\)](#) form through normal processing channels (not Timely Filing), regardless of the DOS.
- Indicate the reason for the overpayment, such as a duplicate reimbursement or an error in the quantity indicated on the claim.

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

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

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

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

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

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

Topic #8417

Voiding Claims

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

Responses

Topic #540

An Overview of the Remittance Advice

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

Providers are required to access their secure [ForwardHealth provider Portal account](#) to obtain their RA.

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

Topic #5091

National Provider Identifier on the Remittance Advice

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

Topic #4818

Calculating Totals on the Remittance Advice for Adjusted and Paid Claims

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

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

Topic #534

Claim Number

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

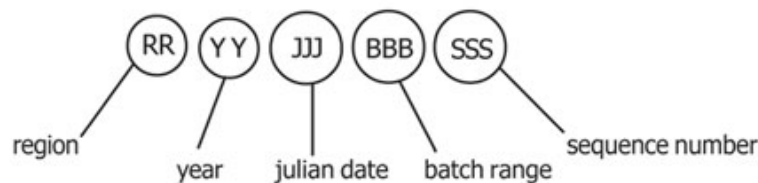
control number)). However, denied real-time compound and noncompound claims are not assigned an ICN, but receive an authorization number. Authorization numbers are not reported to the RA (Remittance Advice) or 835 (835 Health Care Claim Payment/Advice).

Interpreting Claim Numbers

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

Interpreting Claim Numbers

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



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

Topic #535

Claim Status

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

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

Topic #644

ClaimCheck Review

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

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

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

Areas Monitored by ClaimCheck

ForwardHealth uses ClaimCheck software to monitor the following situations:

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

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

Unbundled Procedures

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

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

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

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

Incidental/Integral Procedures

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

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

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

Mutually Exclusive Procedures

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

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

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

Medical Visit Billing Errors

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

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

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

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

Preoperative and Postoperative Billing Errors

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

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

Medically Obsolete Procedures

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

Assistant Surgeon Billing Errors

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

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

Gender-Related Billing Errors

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

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

Payments Denied as a Result of the ClaimCheck Review

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

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

If a provider disagrees with ClaimCheck's determination, the provider may resubmit the claim with supporting documentation to Provider Service Written Correspondence. If the original claim is in an allowed status, the provider may submit an [Adjustment/Reconsideration Request \(F-13046 \(07/12\)\)](#) with supporting documentation and the words "medical consultant

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

Topic #4746

Cutback Fields on the Remittance Advice for Adjusted and Paid Claims

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

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

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

Topic #8617

Duplicate Claim Denials Within Seven Days

If a pharmacy's drug claim with an NDC (National Drug Code) is received by ForwardHealth and a subsequent professional claim for the same drug is received from a clinic with the equivalent drug-related HCPCS (Healthcare Common Procedure Coding System) procedure code having a DOS (date of service) that is within seven days of the pharmacy's DOS, then the clinic's claim will be denied as a duplicate claim. For example, a member may receive albuterol inhalation solution at a clinic and then fill a prescription at the pharmacy for the same drug within seven days. If the first claim received is the pharmacy's drug claim, it will be paid if all billing requirements are met.

These denied claims should be submitted on paper to the following address:

ForwardHealth
Provider Services Written Correspondence
313 Blettner Blvd
Madison WI 53784

Topic #537

Electronic Remittance Information

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

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

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

Text File

The TXT format file is generated by financial payer and listed by RA number and RA date on the secure provider Portal account under the "View Remittance Advices" menu. RAs from the last 97 days are available in the TXT format. When a user clicks on an RA, a pop-up window displays asking if the user would like to "Open" or "Save" the file. If "Open" is chosen, the document opens based on the user's application associated with opening text documents. If "Save" is chosen, the "Save As" window will open. The user can then browse to a location on their computer or network to save the document.

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

Comma-Separated Values Downloadable File

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

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

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

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

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

835

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

Provider Electronic Solutions Software

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 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 11100 (i.e., biopsy of skin lesion) was billed 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 (i.e., removal of a sweat gland lesion) and 93000 (i.e., electrocardiogram) 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

The CMS will issue quarterly revisions to the table of codes subject to NCCI edits that ForwardHealth will adopt and implement. Refer to the [CMS Web site](#) 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 \(07/12\)\)](#) 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 97 days are available in the TXT format.

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

Topic #4745

Overview of Claims Processing Information on the

Remittance Advice

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

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

The [claims processing sections](#) reflect the types of claims submitted, such as the following:

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

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

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

Claim Types on the Remittance Advice and Corresponding Provider Types

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

Topic #4821

Prior Authorization Number on the Remittance Advice

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

Topic #4418

Reading Non-Claims Processing Sections of the Remittance Advice

Address Page

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

Banner Messages

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

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

Explanation of Benefits Code Descriptions

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

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

Financial Transactions Page

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

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

Refunds are payments made to providers for overpayments.

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

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

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

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

Type of Character and Description	Applicable Characters and Description
Transaction — The first character indicates the	V — Capitation adjustment

type of financial transaction that created the accounts receivable.	1 — OBRA Level 1 screening void request 2 — OBRA Nurse Aide Training/Testing void request
Identifier — 10 additional numbers are assigned to complete the Adjustment ICN.	The identifier is used internally by ForwardHealth.

Service Code Descriptions

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

Summary

The Summary section reviews the provider's claim activity and financial transactions with the payer (Medicaid, 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									
XX							PAYEE ID	9999999999999999	
XX							NPI	9999999999	
XX							CHECK/EFT NUMBER	9999999999	
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX XXXXX-XXXX							PAYMENT DATE	MM/DD/CCYY	
--ICN--	PCN	MRN	SERVICE DATES FROM TO		BILLED AMOUNT	OTH INS AMOUNT	SPENDDOWN AMOUNT		
MEMBER NAME: XX MEMBER NO.: XXXXXXXXXXXXXXXX									
RRYYJJBBSSS XXXXXXXXXXXXXX XXXXXXXXXXXXXX MMDDYY MMDDYY 999,999,999.99 9,999,999.99 999,999.99									
HEADER EOB: 9999									
PROC CD	MODIFIERS	ALLW UNITS	SERVICE DATES FROM TO		RENDERING PROVIDER	PA NUMBER BILLED AMT	DETAIL EOB		
XXXXX	XX XX XX XX	9999.99	MMDDYY	MMDDYY	XXX XXXXXXXXXXXXXXXX	XXXXXXXXXX	9999	9999	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
						9,999,999.99	9999	9999	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
XXXXX	XX XX XX XX	9999.99	MMDDYY	MMDDYY	XXX XXXXXXXXXXXXXXXX	XXXXXXXXXX	9999	9999	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
						9,999,999.99	9999	9999	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
XXXXX	XX XX XX XX	9999.99	MMDDYY	MMDDYY	XXX XXXXXXXXXXXXXXXX	XXXXXXXXXX	9999	9999	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
						9,999,999.99	9999	9999	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
XXXXX	XX XX XX XX	9999.99	MMDDYY	MMDDYY	XXX XXXXXXXXXXXXXXXX	XXXXXXXXXX	9999	9999	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
						9,999,999.99	9999	9999	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.

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

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

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

Topic #6237

Reporting a Lost Check

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

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

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

ForwardHealth
Financial Services
313 Blettner Blvd
Madison WI 53784

Topic #5018

Searching for and Viewing All Claims on the Portal

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

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

- Go to the Portal.

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

Topic #4829

Sections of the Remittance Advice

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

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

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

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

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

Remittance Advice Header Information

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

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

- The technical name of the RA section (e.g., CRA-TRAN-R), which is an internal ForwardHealth designation.
- The RA number, which is a unique number assigned to each RA that is generated.
- The name of the payer (Medicaid, 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 #366

Copayment Amounts

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

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

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

Topic #548

Exceptions to the Submission Deadline

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

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

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

Claims or adjustment requests that meet one of the exceptions to the submission deadline may be submitted to [Timely Filing](#).

Topic #547

Submission Deadline

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

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

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

Claims

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

Crossover Claims

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

Topic #517

Usual and Customary Charges

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

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

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

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

Submission

Topic #4659

1500 Health Insurance Claim Form Completion Instructions for Physician Services

The following sample 1500 Health Insurance Claim Forms are available for physician services:

- [Physician Medical Services \(Three Evaluation and Management Visits with Pediatric Modifier\)](#).
- [Physician Radiology Services](#).
- [Physician Surgical Services \(Bilateral Surgery\)](#).
- [Physician Laboratory Services](#).

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

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

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

Submit completed paper claims to the following address:

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

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

Element 1a — Insured's ID Number

Enter the member identification number. Do not enter any other numbers or letters. Use the ForwardHealth card or Wisconsin's EVS (Enrollment Verification System) to obtain the correct member ID.

Element 2 — Patient's Name

Enter the member's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Sex

Enter the member's birth date in MMDDYY format (e.g., February 3, 1955, would be 020355) or in MMDDCCYY format (e.g., February 3, 1955, would be 02031955). Specify whether the member is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name

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

Element 5 — Patient's Address

Enter the complete address of the member's place of residence, if known.

Element 6 — Patient Relationship to Insured (not required)**Element 7 — Insured's Address (not required)****Element 8 — Patient Status (not required)****Element 9 — Other Insured's Name**

Commercial health insurance must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth.

If the EVS indicates that the member has dental ("DEN") insurance only, is enrolled in a Medicare Advantage Plan only, or has no commercial health insurance, leave Element 9 blank.

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

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

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the member has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to, the following: <ul style="list-style-type: none"> • The member denied coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • The member's commercial health insurance failed to respond to initial and follow-up claims. • Benefits are not assignable or cannot get assignment. • Benefits are exhausted.

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

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

Element 9b — Other Insured's Date of Birth, Sex (not required)**Element 9c — Employer's Name or School Name (not required)****Element 9d — Insurance Plan Name or Program Name (not required)****Element 10a-10c — Is Patient's Condition Related to: (not required)****Element 10d — Reserved for Local Use (not required)****Element 11 — Insured's Policy Group or FECA Number**

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

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

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

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

Code	Description
M-7	<p>Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted.</p> <p><i>For Medicare Part A, use M-7 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as enrolled in Medicare Part A. • The member is eligible for Medicare Part A. • The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or exhausted benefits. <p><i>For Medicare Part B, use M-7 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as enrolled in Medicare Part B. • The member is eligible for Medicare Part B. • The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or exhausted benefits.
M-8	<p>Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance.</p> <p><i>For Medicare Part A, use M-8 in the following instances (all three criteria must be met):</i></p>

- The provider is identified in ForwardHealth files as enrolled in Medicare Part A.
- The member is eligible for Medicare Part A.
- The service is usually covered by Medicare Part A but not in this circumstance (e.g., member's diagnosis).

For Medicare Part B, use M-8 in the following instances (all three criteria must be met):

- The provider is identified in ForwardHealth files as enrolled in Medicare Part B.
- The member is eligible for Medicare Part B.
- The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis).

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

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

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

Element 11d — Is There Another Health Benefit Plan? (not required)

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

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

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

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

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

Element 17 — Name of Referring Provider or Other Source (required for evaluation & management [E&M] consultations and laboratory and radiology services only)

Enter the referring physician's name.

Element 17a (not required)

Element 17b — NPI (National Provider Identifier) (required for E&M consultations and laboratory and radiology services only)

Enter the NPI of the referring physician.

Element 18 — Hospitalization Dates Related to Current Services

For [extraordinary claims](#), the provider is required to include the date of admittance and date of discharge.

Element 19 — Reserved for Local Use

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

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

Element 21 — Diagnosis or Nature of Illness or Injury

Enter a valid ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis code for each

symptom or condition related to the services provided. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

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

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

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

Family Planning Services

Indicate the appropriate ICD-9-CM diagnosis code from the V25 series for services and supplies that are only contraceptive management related.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

Element 24

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

Element 24A-24G (shaded area)

These instructions apply to claims submitted for provider-administered drugs. NDCs (National Drug Codes) must be indicated in the shaded area of Elements 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 further instruction on submitting a 1500 claim form with supplemental NDC information, providers may refer to the 1500 Claim Form Reference Instruction manual on the [NUCC \(National Uniform Claim Committee\) Web site](#).

Element 24A — Date(s) of Service

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

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

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

Element 24B — Place of Service

Enter the appropriate two-digit POS code for each item used or service performed.

Element 24C — EMG

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

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. ForwardHealth denies claims received without an appropriate procedure code.

Modifiers

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

Element 24E — Diagnosis Pointer

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

Element 24F — \$ Charges

Enter the total charge for each line item.

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

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

Element 24G — Days or Units

Enter the number of days or units. Only include a decimal when billing fractions (e.g., 1.50).

Element 24H — EPSDT/Family Plan

Enter a "Y" for each family planning procedure. If family planning does not apply, leave this element blank.

Note: Providers should *not* use this element to indicate that a service is a result of a HealthCheck referral.

Element 24I — ID Qual

If the rendering provider's NPI is different from the billing provider number in Element 33a, enter a qualifier of "ZZ," indicating provider taxonomy, in the *shaded area* of the detail line.

Element 24J — Rendering Provider ID. #

If the rendering provider's NPI is different from the billing provider number in Element 33a, enter the rendering provider's 10-digit taxonomy code in the *shaded area* of this element and enter the rendering provider's NPI in the *white area* provided for the NPI.

Element 25 — Federal Tax ID Number (not required)**Element 26 — Patient's Account No. (not required)**

Optional — Providers may enter up to 14 characters of the patient's internal office account number. This number will appear on the R/A (Remittance Advice) and/or the 835 (835 Health Care Claim Payment/Advice) transaction.

Element 27 — Accept Assignment? (not required)**Element 28 — Total Charge**

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

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

Element 29 — Amount Paid

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

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

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

Element 30 — Balance Due

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

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

Element 31 — Signature of Physician or Supplier, Including Degrees or Credentials

The provider or authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MMDDYY or MMDDCCYY format.

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

Element 32 — Service Facility Location Information (not required)

Element 32a — NPI (not required)

Element 32b (not required)

Element 33 — Billing Provider Info & Ph #

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

Element 33a — NPI

Enter the NPI of the billing provider.

Element 33b

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

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

Sample 1500 Health Insurance Claim Form for Physician Medical Services (Three Evaluation and Management Visits with Pediatric Modifier)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> PICA										<input type="checkbox"/> PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (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 SEX MM DD YY M F <input checked="" type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) 609 WILLOW ST										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
7. INSURED'S ADDRESS (No., Street) CITY STATE ANYTOWN WI										8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-P										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO									
11. INSURED'S POLICY OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME										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 (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 10 26 11									
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY 17a. _____ 17b. NPI _____										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____ 22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____ 23. PRIOR AUTHORIZATION NUMBER _____									
19. RESERVED FOR LOCAL USE 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 480.0 2. _____ 3. _____ 4. _____										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) EPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-9 CM I. ID. QUAL J. RENDERING PROVIDER ID. # 1 10 26 11 11 99213 TJ 1 XXX XX 1 NPI 2 11 02 11 11 99213 TJ 1 XXX XX 1 NPI 3 11 07 11 11 99213 TJ 1 XXX XX 1 NPI 4 _____ 5 _____ 6 _____									
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/> 26. PATIENT'S ACCOUNT NO. 1234JED 27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ XXX XX 29. AMOUNT PAID \$ XX XX 30. BALANCE DUE \$ XXX XX 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) J. H. Records 11302011 SIGNED DATE										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. 022222220 c. ZZ123456789X									

NUCC Instruction Manual available at: www.nucc.org

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

Sample 1500 Health Insurance Claim Form for Physician Radiology Services

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (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										4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME																													
5. PATIENT'S ADDRESS (No., Street) 609 WILLOW ST										7. INSURED'S ADDRESS (No., Street)																													
CITY ANYTOWN					STATE WI					CITY					STATE																								
ZIP CODE 55555					TELEPHONE (Include Area Code) (444) 444-4444					ZIP CODE					TELEPHONE (Include Area Code)																								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-P										11. INSURED'S POLICY GROUP OR FECA NUMBER																													
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																													
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. EMPLOYER'S NAME OR SCHOOL NAME																													
c. EMPLOYER'S NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME																													
d. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																													
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 _____ DATE _____																			
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE I.M. REFERRING PROVIDER										17a. NPI 0111111110										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to item 24E by line) 1. 959.09 3. _____										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. #/SET Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																																							
1 02 01 12 11 70100 26 1 XXX XX 1 ZZ 123456789X																				NPI 0222222220																			
2																				NPI																			
3																				NPI																			
4																				NPI																			
5																				NPI																			
6																				NPI																			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 1234JED										27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO																			
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.) J.M. Provider 02012012 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. 0333333330 b. ZZ123456789X																			
28. TOTAL CHARGE \$ XXX XX										29. AMOUNT PAID \$ XX XX										30. BALANCE DUE \$ XX XX																			

NUCC Instruction Manual available at: www.nucc.org

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

Sample 1500 Health Insurance Claim Form for Physician Surgical Services (Bilateral Surgery)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (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		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME	
5. PATIENT'S ADDRESS (No., Street) 609 WILLOW ST		7. INSURED'S ADDRESS (No., Street) 	
CITY ANYTOWN STATE WI		CITY STATE	
ZIP CODE 55555 TELEPHONE (Include Area Code) (444) 444-4444		ZIP CODE TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-P		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
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 (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to item 24E by line) 1. 996 . 79 3. _____		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
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		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
11 14 11 21 19370 50 1		23. PRIOR AUTHORIZATION NUMBER	
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		F. \$ CHARGES G. DAYS OR UNITS H. #/SET Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #	
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>J. M. Provider</i> 11302011		28. TOTAL CHARGE \$ XXX XX 29. AMOUNT PAID \$ XX XX 30. BALANCE DUE \$ XX XX	
32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234	
SIGNED _____ DATE _____		a. 0222222220 b. ZZ123456789X	

NUCC Instruction Manual available at: www.nucc.org

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

Sample 1500 Health Insurance Claim Form for Physician Laboratory Services

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (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		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME	
3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	
5. PATIENT'S ADDRESS (No., Street) 609 WILLOW ST CITY ANYTOWN STATE WI		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-P a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE	
<p>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> <p>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.</p> <p>SIGNED _____ DATE _____</p> <p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p> <p>SIGNED _____</p>			
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE I.M. REFERRING PROVIDER		17a. NPI 0111111110	
19. RESERVED FOR LOCAL USE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to item 24E by Line) 1. V18.3 3. _____ 2. _____ 4. _____		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EP01 Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #	
1 02 01 12 11 85576 26 1 XXX XX 1 ZZ 123456789X		NP1 0222222220	
2		NP1	
3		NP1	
4		NP1	
5		NP1	
6		NP1	
25. FEDERAL TAX I.D. NUMBER SSN EIN 1234JED		26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
28. TOTAL CHARGE \$ XXX XX 29. AMOUNT PAID \$ XX XX 30. BALANCE DUE \$ XX XX		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) J.H. Provider 02012012 SIGNED DATE	
32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. ZZ123456789X		33. BILLING PROVIDER INFO & PH # I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234 a. 0333333330 b. ZZ123456789X	

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Topic #10677

Advanced Imaging Services

Claims for advanced imaging services should be submitted to ForwardHealth using normal procedures and claim completion

instructions. When PA (prior authorization) is required, providers should always wait two full business days from the date on which [MedSolutions](#) approved the PA request before submitting a claim for an advanced imaging service that requires PA. This will ensure that ForwardHealth has the PA on file when the claim is received.

Submitting Claims for Situations Exempt from the Prior Authorization Requirement

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

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

Service Provided During an Inpatient Stay

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

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

Service Provided for Observation Status

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

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

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

Service Provided as Part of Emergency Room Visit

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

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

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

Service Provided as Emergency Service

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

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

guide for instructions on including a modifier.

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

Ordering Provider Is Exempt from Prior Authorization Requirement

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

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

Topic #542

Attached Documentation

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

Topic #813

Examples of Required Additional Claim Documentation for Physician Services Providers

Examples of when physician services providers are required to attach documentation to a paper claim include:

- An [Abortion Certification Statements \(F-1161 \(10/08\)\)](#) form is attached to an abortion surgery claim.
- Physician-administered drugs that are not on the physician services [maximum allowable fee schedule](#) or unclassified drugs that do not require PA (prior authorization).
- Surgeries performed by cosurgeons.

Providers should note that additional documentation can also be uploaded via the Portal for most electronically submitted claims.

Topic #2605

Claim Submission for Clozapine Management Services

BadgerCare Plus and Wisconsin Medicaid reimburse a single fee for clozapine management services provided either once per calendar week (i.e., Sunday through Saturday) or once per two calendar weeks. Providers indicate a quantity of 1.0 for each billing period. For members who have weekly WBC (white blood cell) counts, providers will only be allowed to bill clozapine management once (up to 4.0 units) per week, regardless of the number of services provided during a week. For those members who have WBC counts taken every other week, providers will only be allowed to bill clozapine management once (up to 4.0 units) every two weeks.

A quantity of no more than four 15-minute time units per DOS (date of service) may be indicated on the claim. Providers may submit claims for clozapine management only as often as a member's WBC count and ANC (absolute neutrophil count) are tested, even if clozapine is dispensed more frequently. Documentation must support the actual time spent on clozapine management services.

Providers submit claims for clozapine management services using the 837P (837 Health Care Claim: Professional) transaction or paper 1500 Health Insurance Claim Form. For each billing period, only one provider per member may be reimbursed for clozapine management with procedure code H0034 (Medication training and support, per 15 minutes) and modifier "UD" (clozapine management).

Billing Units for Clozapine Management Services	
Quantity	Time
1.0	1-15 minutes
2.0	16-30 minutes
3.0	31-45 minutes
4.0	46-60 minutes

Place of Service Codes

Allowable POS (place of service) codes for clozapine management services are listed in the following table.

Place of Service Code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
22	Outpatient Hospital
34	Hospice
71	State or Local Public Health Clinic
99	Other Place of Service

Topic #14437

Claim Submission for Lumizyme and Myozyme

Claims for Lumizyme and Myozyme must be submitted on a professional claim using the ForwardHealth Portal, the 837P (837 Health Care Claim: Professional) transaction, or the 1500 Health Insurance Claim Form.

On each claim submission, prescribers are required to indicate the following:

- HCPCS (Healthcare Common Procedure Coding System) procedure code J0221 (Injection, alglucosidase alfa,

- [lumizyme], 10 mg) for Lumizyme or J0220 (Injection, alglucosidase alfa, not otherwise specified, 10 mg) for Myozyme.
- The dosage in number of 10 milligram units administered. Lumizyme and Myozyme only come in 50 milligram vials; therefore, one vial is equal to five units. Prescribers may submit claims for partially used vials of Lumizyme and Myozyme.
- The appropriate procedure code, which must match the procedure code that was approved on the PA (prior authorization) request.

To comply with the requirements of the DRA (Deficit Reduction Act of 2005), the following must also be indicated on claims for Lumizyme and Myozyme:

- The NDC (National Drug Code) of the drug dispensed.
- The code qualifier ME (milligrams).
- The quantity of milligrams dispensed.

Note: Outpatient pharmacy claims billed with an NDC will be denied.

Example of How Units Are Determined for Billing

The following is an example (using Lumizyme) of how the number of units would be determined for billing:

- With Lumizyme dosed at 20 milligrams/kilogram, the dose for a member weighing 68 kilograms (150 pounds) is 1,360 milligrams (20 multiplied by 68).
- At 50 milligrams per vial, the number of vials required is 27.2 (1,360 divided by 50).
- 27.2 vials is rounded up to 28 vials (allowing prescribers to bill for waste).
- 28 vials (at 50 milligrams per vial) equals 1,400 milligrams.
- 1,400 milligrams (indicated in 10 milligram units) equals 140 units to be billed.

Topic #15117

Claim Submission for OnabotulinumtoxinA (Botox®)

Professional Claims for Botox®

Professional claims for Botox® should be submitted according to the claims submission requirements for [provider-administered drugs](#) (including the requirements for compliance with the DRA (Deficit Reduction Act of 2005)).

Example of How to Determine Number of Units for Billing

The following is an example of how the number of units would be determined when billing Botox® on a professional claim.

Note: This is an example only. Providers are required to determine the appropriate codes/units to bill based on the specific details of the treatment administered. Providers should note that 100-unit and 200-unit vials of Botox® have different NDCs (National Drug Codes). In all cases, the provider should bill in the manner that produces the least amount of waste.

Example

A member received the standard treatment dose of Botox® for chronic migraines, which is 155 units.

Since Botox® comes in 100-unit and 200-unit single-use vials, the rendering provider could have used either one

200-unit vial or two 100-unit vials. (ForwardHealth allows billing for waste in either case.) For this example, the rendering provider used one 200-unit vial.

On the professional claim for this example, the number of units for the HCPCS (Healthcare Common Procedure Coding System) procedure code and the NDC would be indicated as follows:

- For HCPCS procedure code J0585 (Injection, onabotulinumtoxinA, 1 unit), 200 units would be indicated (including the 45 units of waste).
- For NDC N400023392102 UN1, one unit would be indicated (representing the number of 200-unit vials used).

Topic #6957

Copy Claims on the ForwardHealth Portal

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

Topic #5017

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

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

Topic #4997

Direct Data Entry of Professional and Institutional Claims on the Portal

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

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

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

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

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

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

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

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

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

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

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

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

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

Topic #15957

Documenting and Billing the Appropriate National Drug Code

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

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

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

Topic #344

Electronic Claim Submission

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

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

Topic #641

Electronic Claim Submission for Physician Services

Electronic claims for physician services must be submitted using the 837P (837 Health Care Claim: Professional) transaction. Electronic claims for physician 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 DHCAA (Division of Health Care Access and Accountability) offers electronic billing software at no cost to providers. The PES (Provider Electronic Solutions) software allows providers to submit electronic claims using an 837 transaction. To obtain PES software, providers may download it from the [ForwardHealth Portal](#). For assistance installing and using PES software, providers may call the [EDI \(Electronic Data Interchange\) Helpdesk](#).

Topic #365

Extraordinary Claims

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

Topic #4837

HIPAA-Compliant Data Requirements

Procedure Codes

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

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

Provider Numbers

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

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

Topic #562

Managed Care Organizations

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

Topic #10837

Note Field for Most Claims Submitted Electronically

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

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

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

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

- Professional.
- Institutional.
- Dental.

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

Claims Submitted Via 837 Health Care Claim Transactions

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

Topic #561

Paper Claim Form Preparation and Data Alignment Requirements

Optical Character Recognition

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

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

Speed and Accuracy of Claims Processing

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

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

Handwritten Claims

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

Use Original Claim Forms

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

Use Laser or Ink Jet Printers

It is recommended that claims are printed using laser or ink jet printers rather than printers that use DOT matrix. DOT matrix printers have breaks in the letters and numbers, which may cause the OCR software to misread the claim form. Use of old or

worn ink cartridges should also be avoided. If the claim form is read incorrectly by the OCR software, the claim may be denied or reimbursed incorrectly. The process may also be stopped if it is unable to read the claim form, which will cause a delay while it is manually reviewed.

Alignment

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

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

The following sample claim forms demonstrate correct and incorrect alignment:

- [Correct alignment](#) for the 1500 Health Insurance Claim Form.
- [Incorrect alignment](#) for the 1500 Health Insurance Claim Form.
- [Correct alignment](#) for the UB-04 Claim Form.
- [Incorrect alignment](#) for the UB-04 Claim Form.

Clarity

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

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

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

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

Staples, Correction Liquid, and Correction Tape

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

Additional Diagnosis Codes

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

Anchor Fields

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

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

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

- Form Locator 4 (Type of Bill).
- Form Locator 5 (Fed. Tax No.).
- Form Locator 9 (Patient Address).
- Form Locator 58A (Insured's Name).

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

Sample of a Correctly Aligned 1500 Health Insurance Claim Form

1500											
HEALTH INSURANCE CLAIM FORM											
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05											
PICA											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (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 M F <input checked="" type="checkbox"/>		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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)				
CITY ANYTOWN			STATE WI		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE		
ZIP CODE 55555			TELEPHONE (Include Area Code) (444) 444-4444		Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Student <input type="checkbox"/> Part-Time <input type="checkbox"/>		ZIP CODE		TELEPHONE (Include Area Code)		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) O-I-P					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. INSURED'S DATE OF BIRTH MM DD YY M F <input type="checkbox"/>					SEX <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M F <input type="checkbox"/>					b. EMPLOYER'S NAME OR SCHOOL NAME					c. INSURANCE PLAN NAME OR PROGRAM NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME					10x. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
d. INSURANCE PLAN NAME OR PROGRAM NAME					12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE I.M. REFERRING PROVIDER					17a. NPI 0111111110					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. LXXX, X 3. _____ 2. _____ 4. _____					23. PRIOR AUTHORIZATION NUMBER					24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DATES OR UNITS H. ICD-9-CM I. ID. QUAL J. RENDERING PROVIDER ID. #	
1 MM DD YY XX XXXX XX X XXX XX 1 NPI					2 NPI					3 NPI	
4 NPI					5 NPI					6 NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 1234JED					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	
28. TOTAL CHARGE \$ XXX XX					29. AMOUNT PAID \$ XX XX					30. BALANCE DUE \$ XX XX	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) J. M. Provider					32. SERVICE FACILITY LOCATION INFORMATION 1 W WILLIAMS ST ANYTOWN WI 55555-1234					33. BILLING PROVIDER INFO & PH # 0222222220 ZZ123456789X	
SIGNED _____ DATE _____					a. NPI					b. ZZ123456789X	

NUCC Instruction Manual available at: www.nucc.org

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

Sample of an Incorrectly Aligned 1500 Health Insurance Claim Form

1500									
HEALTH INSURANCE CLAIM FORM									
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05									
PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLX (LUNG) <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. INSURED'S I.D. NUMBER	
MEMBER, IM A		MM DD YY		M F		SAME		1234567890	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)		8. PATIENT STATUS		9. INSURED'S ADDRESS (No., Street)	
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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		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
O-P		a. EMPLOYMENT? (Current or Previous)		a. INSURED'S DATE OF BIRTH		b. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. AUTO ACCIDENT?		b. INSURED'S DATE OF BIRTH		c. EMPLOYER'S NAME OR SCHOOL NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
b. OTHER INSURED'S DATE OF BIRTH		c. OTHER ACCIDENT?		c. EMPLOYER'S NAME OR SCHOOL NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		If yes, return to and complete item 9 a-d.	
c. EMPLOYER'S NAME OR SCHOOL NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		If yes, return to and complete item 9 a-d.			
d. INSURANCE PLAN NAME OR PROGRAM NAME				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		If yes, return to and complete item 9 a-d.			
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY									
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY									
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE I.M. REFERRING PROVIDER									
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
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20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to item 24E by Line) 1. XXX X									
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES E. DIAGNOSIS F. G. DAYS OR UNITS H. I. ID. QUAL. J. RENDERING PROVIDER ID. # From MM DD YY To MM DD YY SERVICE EMG CPT/HCPCS MODIFIER POINTER \$ CHARGES									
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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.) J. M. Provider MMDDCCYY									
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 APPROVED OMB 0988-0999 FORM CMS-1500 (08-05)

Sample of an Incorrectly Aligned UB-04 Claim Form

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Paper claims for physician services must be submitted using the 1500 Health Insurance Claim Form (dated 08/05). ForwardHealth denies claims for physician services submitted on any other claim form.

Providers should use the appropriate claim form instructions for physician 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 #10177

Prior Authorization Numbers on Claims

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

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

Topic #4382

Provider-Administered Drugs

Deficit Reduction Act of 2005

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

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

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

Radiopharmaceuticals are included in the DRA requirements. Providers will be required to indicate NDCs with HCPCS procedure codes on claims for radiopharmaceuticals.

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

Less-Than-Effective Drugs

ForwardHealth will deny provider-administered drug claims for LTE (less-than-effective) or identical, related, or similar drugs for ForwardHealth members.

Medicare Crossover Claims

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

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

340B Providers

Providers who participate in the 340B Drug Pricing Program are required to indicate an NDC on claims for provider-administered drugs. The 340B Drug Pricing Program allows certain federally funded grantees and other health care providers to purchase prescription drugs at significantly reduced prices. When submitting the 340B billed amount, they are also required to indicate the actual acquisition cost plus a reasonable dispensing fee.

Explanation of Benefits Codes on Claims for Provider-Administered Drugs

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

Provider-Administered Claim Denials

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

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

Provider-Administered Drugs and Administration Codes Reimbursed by Managed Care Organizations

For members enrolled in BadgerCare Plus HMOs, Medicaid SSI (Supplemental Security Income) HMOs, and most special managed care programs, BadgerCare Plus and Medicaid fee-for-service, not the member's MCO (managed care organization), reimburse providers for the following if the service is covered by BadgerCare Plus and Medicaid:

- All "J" codes.
- Drug-related "Q" codes.
- A limited number of related [administration codes](#).

This policy is known as the provider-administered drugs carve out policy. For members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, claims for "J" codes, drug-related "Q" codes, and administration code services should be submitted to BadgerCare Plus and Medicaid fee-for-service.

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

Provider-administered drugs and related services for members enrolled in the PACE (Program for All-Inclusive Care for the

Elderly) and the Family Care Partnership are provided and reimbursed by the special managed care program.

Exemptions

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

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

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

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

Additional Information

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

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

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

- The [FDA \(Food and Drug Administration\) Web site.](#)
- The [Drug Search Tool.](#) (Providers may verify if an NDC and its segments are valid using this Web site.)

Topic #10237

Claims for Provider-Administered Drugs

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

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

1500 Health Insurance Claim Form

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

- Indicate the NDC qualifier "N4," followed by the 11-digit NDC of the drug dispensed, with no space in between.
- Indicate one space between the NDC and the unit qualifier.
- Indicate one unit qualifier (F2 [International unit], GR [Gram], ME [Milligram], ML [Milliliter], or UN [Unit]), followed by the NDC units, with no space in between. For further instruction on submitting a 1500 claim form with supplemental NDC information, providers may refer to the 1500 Claim Form Reference Instruction manual on the [NUCC \(National Uniform Claim Committee\) Web site.](#)

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

837 Health Care Claim: Professional Transactions

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

Direct Data Entry on the ForwardHealth Portal

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

- The NDC of the drug dispensed.
- Quantity unit.
- Unit of measure.

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

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. The PES software allows providers to submit 837P transactions, adjust claims, and check claim status. To obtain PES software, providers may download it from the [ForwardHealth Portal](#). For assistance installing and using PES software, providers may call the [EDI \(Electronic Data Interchange\) Helpdesk](#).

Topic #10637

Reimbursement Reduction for Most Paper Claims

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

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

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

The reimbursement reduction applies to the following paper claims:

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

Exceptions to Paper Claim Reimbursement Reduction

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

- In-state emergency providers.

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

Topic #1159

Routine Foot Care

A referring physician is not required to be indicated on the claim when submitting claims for routine foot care, but the name of the primary or attending physician must be documented in the member's medical record. When routine foot care services include multiple digits on either one or both feet, Wisconsin Medicaid reimburses a single fee for the service.

If routine foot care is performed in the nursing home for several nursing home members on the same DOS (date of service), the podiatrist must indicate the procedure code SO390 (Routine foot care; removal and/or trimming of corns, calluses and/or nails and preventive maintenance in specific medical conditions (e.g., diabetes), per visit) for a single member. Wisconsin Medicaid will reimburse the normal maximum allowable fee for an established patient visit for this member. Claims for all other members seen in the nursing home on that DOS must be submitted indicating the procedure code 99311 (Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient), and they will be reimbursed at a reduced rate. Providers should submit a separate claim for each member seen on the same DOS.

Topic #15977

Submitting Multiple National Drug Codes per Procedure Code

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

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

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

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

paired with different NDCs.

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

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

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

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

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

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

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

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

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

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

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

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

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

Topic #4817

Submitting Paper Attachments with Electronic Claims

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

Paper attachments that go with electronic claim transactions must be submitted with the [Claim Form Attachment Cover Page \(F-13470 \(10/08\)\)](#). Providers are required to indicate an ACN (attachment control number) for paper attachment(s) submitted with electronic claims. (The ACN is an alphanumeric entry between 2 and 80 digits assigned by the provider to identify the attachment.) The ACN must be indicated on the cover page so that ForwardHealth can match the paper attachment(s) to the correct electronic claim.

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

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

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

This does not apply to compound and noncompound claims.

Topic #15317

Surgical Procedures Billed on Professional Claims

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

Topic #1951

Synagis

Synagis[®] (palivizumab), a monoclonal antibody, is used to prevent lower respiratory tract diseases caused by RSV (respiratory syncytial virus) in premature, high-risk infants. The prevalence for RSV is from October through April and the treatment season in the northern hemisphere is generally from November through March. The general recommendation for treatment with Synagis during a treatment season is to administer the first dose in November and the last dose in March.

[PA \(prior authorization\)](#) is required for Synagis[®].

Synagis[®] is not part of the provider-administered drugs carve-out policy; therefore, a member's MCO (managed care

organization) should reimburse providers for Synagis®.

Professional Claim Submission

Claims for Synagis® must be submitted using the 837P (837 Health Care Claim: Professional) transaction or on the 1500 Health Insurance Claim Form. Prescribers and pharmacy providers are required to indicate CPT (Current Procedural Terminology) procedure code 90378 (Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each) and the appropriate unit(s) on each claim submission. To comply with the requirements of the DRA (Deficit Reduction Act), the NDC (National Drug Code) of the drug dispensed, the quantity, qualifier, and unit dispensed must also be indicated on claims for Synagis®.

Pharmacy providers should indicate modifier "U1" on claims for Synagis® to obtain reimbursement for the dispensing fee.

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

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

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

24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS				E.	F.		G.	H.	I.	J.
From To										EMG		MODIFIER				DIAGNOSIS POINT	\$ CHARGES		DAYS OR UNITS	PSOT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY																		
N460574411101 ME100																							
03	01	13	03	01	13	11						90378	KP			13		500	00	2	N	NP1	0123456789
N460574411201 ME50																							
03	01	13	03	01	13	11						90378	KQ			13		500	00	1	N	NP1	0123456789

Dosage Criteria

The following table lists weight-based criteria for Synagis®.

Weight Range (in kg)	Synagis® Calculated Dose	Number of Units*
Up to 3.6 kg	0 - 54 mg	1
3.7 to 6.9 kg	55 mg - 104 mg	2
7.0 to 10.2 kg	105 mg - 154 mg	3
10.3 to 13.6 kg	155 mg - 204 mg	4
13.7 to 16.9 kg	205 mg - 254 mg	5
17.0 to 20.3 kg	255 mg - 304 mg	6

* Units are a 50 mg dose.

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.

Topic #3564

Vaccines

Providers are required to indicate the procedure code of the actual vaccine administered, not the administration code, on claims for all immunizations. Reimbursement for both the vaccine, when appropriate, and the administration are included in the reimbursement for the vaccine procedure code, so providers should not separately bill the administration code. Providers are required to indicate their usual and customary charge for the service with the procedure code.

Sample Reimbursement Scenario

A mother and her 10-year-old child are both BadgerCare Plus Standard Plan members and they both receive an influenza virus vaccine at a physician's office. The influenza virus vaccine is available through the VFC (Vaccines for Children) Program. The child's vaccine is obtained from the provider's VFC supply. The mother's vaccine is obtained from the provider's private stock.

To submit a claim for the child's vaccine, indicate CPT (Current Procedural Terminology) procedure code 90658 (Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use) with the usual and customary charge. ForwardHealth will reimburse for the administration fee only.

To submit a claim for the mother's vaccine, indicate procedure code 90658 with the usual and customary charge. ForwardHealth will reimburse for the vaccine and the administration fee.

Timely Filing Appeals Requests

Topic #549

Requirements

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

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

Topic #551

Resubmission

Decisions on [Timely Filing Appeals Requests \(F-13047 \(07/12\)\)](#) cannot be appealed. Providers may resubmit the claim to Timely Filing if both of the following occur:

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

Topic #744

Submission

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

- A properly completed [Timely Filing Appeals Request \(F-13047 \(07/12\)\)](#) form for each claim and each adjustment to allow for electronic documentation of individual claims and adjustments submitted to ForwardHealth.
- A legible claim or adjustment request.
- All required documentation as specified for the exception to the submission deadline.

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

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

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

Change in Nursing Home Resident's Level of Care or Liability Amount

Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when a nursing home claim is initially received within the submission deadline and reimbursed incorrectly due to a change in the member's authorized level of care or liability amount.	To receive consideration, the request must be submitted within 455 days from the DOS and the correct liability amount or level of care must be indicated on the Adjustment/Reconsideration Request (F-13046 (07/12)) form. The most recent claim number (also known as the ICN (internal control number)) must be indicated on the Adjustment/Reconsideration Request form. This number may be the result of a ForwardHealth-initiated adjustment.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Decision Made by a Court, Fair Hearing, or the Department of Health Services

Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when a decision is made by a court, fair hearing, or the DHS (Department of Health Services).	To receive consideration, the request must be submitted within 90 days from the date of the decision of the hearing. A complete copy of the notice received from the court, fair hearing, or DHS must be submitted with the request.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Denial Due to Discrepancy Between the Member's Enrollment Information in ForwardHealth interChange and the Member's Actual Enrollment

Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when a claim is initially received by the deadline but is denied due to a discrepancy between the member's enrollment information in ForwardHealth interChange and the member's actual enrollment.	To receive consideration, the following documentation must be submitted within 455 days from the DOS: <ul style="list-style-type: none"> A copy of remittance information showing the claim was submitted in a timely manner and denied with a qualifying enrollment-related explanation. A photocopy of one of the following indicating enrollment on the DOS: <ul style="list-style-type: none"> White paper BadgerCare Plus EE (Express Enrollment) for pregnant women or children identification card. White paper TE (Temporary Enrollment) for Family Planning Only Services identification card. The response received through Wisconsin's EVS (Enrollment Verification System) from a commercial eligibility vendor. The transaction log number received through WiCall. 	ForwardHealth Good Faith/Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

ForwardHealth Reconsideration or Recoupment

Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when ForwardHealth reconsiders a previously processed claim. ForwardHealth will initiate an adjustment on a previously paid claim.	If a subsequent provider submission is required, the request must be submitted within 90 days from the date of the RA (Remittance Advice) message. A copy of the RA message that shows the ForwardHealth-initiated adjustment must be submitted with the request.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Retroactive Enrollment for Persons on General Relief

Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when the local county or tribal agency requests a return of a GR (general relief) payment from the provider because a member has become retroactively enrolled for Wisconsin Medicaid or BadgerCare Plus.	To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the member's enrollment information. The request must be submitted with one of the following: <ul style="list-style-type: none"> • "GR retroactive enrollment" indicated on the claim. • A copy of the letter received from the local county or tribal agency. 	ForwardHealth GR Retro Eligibility Ste 50 313 Blettner Blvd Madison WI 53784

Medicare Denial Occurs After the Submission Deadline

Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when claims submitted to Medicare (within 365 days of the DOS) are denied by Medicare after the 365-day submission deadline. A waiver of the submission deadline will not be granted when Medicare denies a claim for one of the following reasons: <ul style="list-style-type: none"> • The charges were previously submitted to Medicare. • The member name and identification number do not match. • The services were previously denied by Medicare. • The provider retroactively applied for Medicare enrollment and did not become enrolled. 	To receive consideration, the following must be submitted within 90 days of the Medicare processing date: <ul style="list-style-type: none"> • A copy of the Medicare remittance information. • The appropriate Medicare disclaimer code must be indicated on the claim. 	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Refund Request from an Other Health Insurance Source

Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when an other health insurance source reviews a previously paid claim and determines that reimbursement was inappropriate.	To receive consideration, the following documentation must be submitted within 90 days from the date of recoupment notification:	ForwardHealth Timely Filing Ste 50

	<ul style="list-style-type: none"> • A copy of the commercial health insurance remittance information. • A copy of the remittance information showing recoupment for crossover claims when Medicare is recouping payment. 	313 Blettner Blvd Madison WI 53784
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Retroactive Member Enrollment		
Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when a claim cannot be submitted within the submission deadline due to a delay in the determination of a member's retroactive enrollment.	To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the member's enrollment information. In addition, "retroactive enrollment" must be indicated on the claim.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Coordination of Benefits

2

Archive Date:01/02/2014

Coordination of Benefits:Commercial Health Insurance

Topic #595

Assignment of Insurance Benefits

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

Commercial health insurance companies may permit reimbursement to the provider or member. Providers should verify whether commercial health insurance benefits may be assigned to the provider. As indicated by the commercial health insurance, providers may be required to obtain approval from the member for this assignment of benefits.

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

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

Topic #844

Claims for Services Denied by Commercial Health Insurance

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

Topic #598

Commercial Fee-for-Service

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

Topic #599

Commercial Managed Care

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

Commercial managed care plans require members to use a designated network of providers. Non-network providers (i.e.,

providers who do not have a contract with the member's commercial managed care plan) will be reimbursed by the commercial managed care plan *only* if they obtain a referral or provide an emergency service.

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

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

Topic #601

Definition of Commercial Health Insurance

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

Topic #602

Discounted Rates

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

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

Topic #596

Exhausting Commercial Health Insurance Sources

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

Step 1. Determine if the Member Has Commercial Health Insurance
<p>If Wisconsin's EVS (Enrollment Verification System) does not indicate that the member has commercial health insurance, the provider may submit a claim to ForwardHealth unless the provider is otherwise aware of commercial health insurance coverage.</p> <p>If the member disputes the information as it is indicated in the EVS, the provider should submit a completed Other Coverage Discrepancy Report (F-01159 (09/12)) form. Unless the service does not require other health insurance billing, the provider should allow at least two weeks before proceeding to Step 2.</p>
Step 2. Determine if the Service Requires Other Health Insurance Billing

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

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

- The provider is encouraged to bill commercial health insurance if he or she believes that benefits are available. Reimbursement from commercial health insurance may be greater than the Medicaid-allowed amount. If billing commercial health insurance first, the provider should proceed to Step 3.
- The provider may submit a claim without indicating an other insurance indicator on the claim.

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

Step 3. Identify Assignment of Commercial Health Insurance Benefits

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

The provider should proceed in one of the following ways:

- **If the provider is assigned benefits**, the provider should bill commercial health insurance and proceed to Step 4.
- **If the member is assigned insurance benefits**, the provider may submit a claim (without billing commercial health insurance) using the appropriate other insurance indicator.

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

Step 4. Bill Commercial Health Insurance and Follow Up

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

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

Step 5. Submit Claim to ForwardHealth

If only partial reimbursement is received, if the correct and complete claim is denied by commercial health insurance, or if commercial health insurance does not respond to the original and follow-up claims, the provider may submit a claim to ForwardHealth using the appropriate other insurance indicator. Commercial remittance information should not be attached to the claim.

Topic #263

Members Unable to Obtain Services Under Managed Care Plan

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

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

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

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

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

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

Topic #604

Non-Reimbursable Commercial Managed Care Services

Providers are not reimbursed for the following:

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

Topic #605

Other Insurance Indicators

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

Other insurance indicators identify the status and availability of commercial health insurance. The indicators allow providers to be reimbursed correctly when the following occur:

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

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

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

Documentation Requirements

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

Topic #603

Services Not Requiring Commercial Health Insurance Billing

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

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

Topic #769

Services Requiring Commercial Health Insurance Billing

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

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

- RHC (rural health clinic) services.
- Skilled nursing home care, if any DOS (date of service) is within 30 days of the date of admission. If benefits greater than 30 days are available, the nursing home is required to continue to bill for them until those benefits are exhausted.
- Vision services over \$50, unless provided in a home, nursing home, or SNF.

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

- Ophthalmology services.
- Optometrist services.

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

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

ForwardHealth has identified [services requiring Medicare billing](#).

Medicare

Topic #664

Acceptance of Assignment

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

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

Topic #666

Claims Denied for Errors

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

Topic #668

Claims Processed by Commercial Insurance That Is Secondary to Medicare

If a crossover claim is also processed by commercial health insurance that is secondary to Medicare (e.g., Medicare supplemental), the claim will not be forwarded to ForwardHealth. After the claim has been processed by the commercial health insurance, the provider should submit a provider-submitted crossover claim to ForwardHealth with the appropriate other insurance indicator.

Topic #670

Claims That Do Not Require Medicare Billing

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

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

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

Topic #704

Claims That Fail to Cross Over

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

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

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

If automatic crossover claims do not appear on the RA after 30 days of the Medicare processing date, providers are required to resubmit the claim directly to ForwardHealth using the NPI that was reported to ForwardHealth as the primary NPI. Additionally, the taxonomy code and the ZIP+4 code of the practice location on file with ForwardHealth are required when additional data is needed to identify the provider.

Topic #667

Claims for Services Denied by Medicare

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

Topic #671

Crossover Claims

A Medicare crossover claim is a Medicare-allowed claim for a dual eligible or QMB-Only (Qualified Medicare Beneficiary-Only) member sent to ForwardHealth for payment of coinsurance, copayment, and deductible.

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

- Medicare Part A fiscal intermediary.
- Medicare Part B carrier.
- Medicare DME (durable medical equipment) regional carrier.
- Medicare Advantage Plan.
- Railroad Retirement Board carrier (also known as the Railroad Medicare carrier).

There are two types of crossover claims based on who submits them:

- Automatic crossover claims.

- Provider-submitted crossover claims.

Automatic Crossover Claims

An automatic crossover claim is a claim that Medicare automatically forwards to ForwardHealth by the COBC (Coordination of Benefits Contractor).

Claims will be forwarded if the following occur:

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

Provider-Submitted Crossover Claims

A provider-submitted crossover claim is a Medicare-allowed claim that a provider directly submits to ForwardHealth when the Medicare claim did not automatically cross over. Providers should submit a provider-submitted crossover claim in the following situations:

- The automatic crossover claim does not appear on the ForwardHealth RA (Remittance Advice) within 30 days of the Medicare processing date.
- The automatic crossover claim is denied and additional information may allow payment.
- The claim is for a member who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (e.g., Medicare Supplemental).
- The claim is for a member who was not enrolled in BadgerCare Plus or Wisconsin Medicaid at the time the service was submitted to Medicare for payment, but the member was retroactively determined enrolled in BadgerCare Plus or Medicaid.
- The claim is for a member who is enrolled in a Medicare Advantage Plan.

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

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

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

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

Topic #672

Definition of Medicare

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

Medicare coverage is divided into four parts:

- Part A (i.e., Hospital Insurance). Part A helps to pay for medically necessary services, including inpatient hospital services, services provided in critical access hospitals (i.e., small facilities that give limited inpatient services and outpatient services to beneficiaries who reside in rural areas), services provided in skilled nursing facilities, hospice services, and some home health services.
- Part B (i.e., Supplemental Medical Insurance). Part B helps to pay for medically necessary services, including physician services, outpatient hospital services, and some other services that Part A does not cover (such as PT (physical therapy) services, OT (occupational therapy) services, and some home health services).
- Part C (i.e., Medicare Advantage).
- Part D (i.e., drug benefit).

Topic #684

Dual Eligibles

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

Dual eligibles may receive coverage for the following:

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

Topic #669

Exhausting Medicare Coverage

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

Adjustment Request for Crossover Claim

The provider may submit a paper or electronic adjustment request. If submitting a paper [Adjustment/Reconsideration Request \(F-13046 \(07/12\)\)](#) form, the provider should attach a copy of Medicare remittance information. (If this is a Medicare reconsideration, copies of the original and subsequent Medicare remittance information should be attached.)

Provider-Submitted Crossover Claim

The provider may submit a provider-submitted crossover claim in the following situations:

- The claim is for a member who is enrolled in a Medicare Advantage Plan.
- The automatic crossover claim is not processed by ForwardHealth within 30 days of the Medicare processing date.
- ForwardHealth denied the automatic crossover claim and additional information may allow payment.
- The claim is for a member who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (e.g., Medicare Supplemental).
- The claim is for a member who was not enrolled in BadgerCare Plus at the time the service was submitted to Medicare for payment, but the member was retroactively enrolled.*

When submitting provider-submitted crossover claims, the provider is required to follow all claims submission requirements in

addition to the following:

- For electronic claims, indicate the Medicare payment.
- For paper claims, the provider is required to do the following:
 - Attach Medicare's remittance information and refrain from indicating the Medicare payment.
 - Indicate "MMC (Medicare Managed Care)" in the upper right corner of the claim for services provided to members enrolled in a Medicare Advantage Plan.

When submitting provider-submitted crossover claims for members enrolled in Medicare and commercial health insurance that is secondary to Medicare, the provider is also required to do the following:

- Refrain from submitting the claim to ForwardHealth until after the claim has been processed by the commercial health insurance.
- Indicate the appropriate other insurance indicator.

* In this situation, a timely filing appeals request may be submitted if the services provided are beyond the claims submission deadline. The provider is required to indicate "retroactive enrollment" on the provider-submitted crossover claim and submit the claim with the [Timely Filing Appeals Request \(F-13047 \(07/12\)\)](#) form. The provider is required to submit the timely filing appeals request within 180 days from the date the backdated enrollment was added to the member's file.

Claim for Services Denied by Medicare

When Medicare denies payment for a service provided to a dual eligible that is covered by BadgerCare Plus or Wisconsin Medicaid, the provider may proceed as follows:

- Bill commercial health insurance, if applicable.
- Submit a claim to ForwardHealth using the appropriate Medicare disclaimer code. If applicable, the provider should indicate the appropriate other insurance indicator. A copy of Medicare remittance information should not be attached to the claim.

Crossover Claim Previously Reimbursed

A crossover claim may have been previously reimbursed by Wisconsin Medicaid when one of the following has occurred:

- Medicare reconsiders services that were previously not allowed.
- Medicare retroactively determines a member eligible.

In these situations, the provider should proceed as follows:

- Refund or adjust Medicaid payments for services previously reimbursed by Wisconsin Medicaid.
- Bill Medicare for the services and follow ForwardHealth's procedures for submitting crossover claims.

Topic #687

Medicare Advantage

Medicare services may be provided to dual eligibles or QMB-Only (Qualified Medicare Beneficiary-Only) members on a fee-for-service basis or through a Medicare Advantage Plan. Medicare Advantage was formerly known as Medicare Managed Care (MMC), Medicare + Choice (MPC), or Medicare Cost (Cost). Medicare Advantage Plans have a special arrangement with the federal CMS (Centers for Medicare and Medicaid Services) and agree to provide all Medicare benefits to Medicare beneficiaries for a fee. Providers may contact Medicare for a list of Medicare Advantage Plans in Wisconsin and the insurance companies with

which they are associated.

Paper Crossover Claims

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

Reimbursement Limits

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

Topic #688

Medicare Disclaimer Codes

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

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

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

Documentation Requirements

Providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation of efforts to bill Medicare to substantiate Medicare disclaimer codes used on any claim, according to [DHS 106.02\(9\)\(a\)](#), Wis. Admin. Code.

Topic #689

Medicare Enrollment

Some providers may become retroactively enrolled in Medicare. Providers should contact Medicare for more information about retroactive enrollment.

Services for Dual Eligibles

As stated in [DHS 106.03\(7\)](#), Wis. Admin. Code, a provider is required to be enrolled in Medicare if both of the following are true:

- He or she provides a Medicare Part A service to a dual eligible.
- He or she can be enrolled in Medicare.

If a provider can be enrolled in Medicare but chooses *not* to be, the provider is required to refer dual eligibles to another Medicaid-enrolled provider who is enrolled in Medicare.

Services for Qualified Medicare Beneficiary-Only Members

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

Topic #8457

Medicare Late Fees

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

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

Resubmitting Medicare Crossover Claims with Late Fees

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

Paper Claim Submissions

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

Electronic Claim Submissions

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

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

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

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

The claim should report the Medicare paid amount as \$80.00.

Topic #690

Medicare Retroactive Eligibility

If a member becomes retroactively eligible for Medicare, the provider is required to refund or adjust any payments for the retroactive period. The provider is required to then bill Medicare for the services and follow ForwardHealth's procedures for submitting crossover claims. Claims found to be in conflict with this program requirement will be recouped.

Topic #895

Modifier for Catastrophe/Disaster-Related Crossover Claims

ForwardHealth accepts modifier "CR" (Catastrophe/disaster related) on Medicare crossover claims (both [837P](#) (837 Health Care Claim: Professional) transactions and 1500 Health Insurance Claim Forms) to accommodate the emergency health care needs of dual eligibles and QMB-Only (Qualified Medicare Beneficiary-Only) members affected by disasters. The [CMS \(Centers for Medicare and Medicaid Services\) Web site](#) contains more information.

Topic #4957

Provider-Submitted Crossover Claims

A provider-submitted crossover claim is a Medicare-allowed claim that a provider directly submits to ForwardHealth when the Medicare claim did not automatically crossover to ForwardHealth.

Electronic Professional Crossover Claims

Providers submitting crossover claims electronically must indicate all Medicare coinsurance, copayment, and psychiatric reduction amounts at the detail level. If the Medicare coinsurance, copayment, and psychiatric reduction amounts are indicated at the header level, the claim will be denied. Providers may indicate deductibles in either the header or detail level.

When submitting electronic Medicare crossover claims, providers should not submit paper EOMB (Explanation of Medicare Benefits) as an attachment. Providers should, however, be sure to complete Medicare CAS segments when submitting 837 transactions.

Paper Professional Crossover Claims Require Provider Signature

All paper provider-submitted crossover claims submitted on the 1500 Health Insurance Claim Form require a provider signature and date in Element 31. The words "signature on file" are not acceptable. Provider-submitted crossover claims without a signature or date are denied or are subject to recoupment. The provider signature requirement for paper crossover claims is the same requirement for all other paper 1500 Health Insurance Claims.

Topic #692

Qualified Medicare Beneficiary-Only Members

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

- Medicare monthly premiums for Part A, Part B, or both.
- Coinsurance, copayment, and deductible for Medicare-allowed services.

QMB-Only members do not receive coverage from Wisconsin Medicaid for services not allowed by Medicare. Therefore, Wisconsin Medicaid will not reimburse for services if either of the following occur:

- Medicare does not cover the service.
- The provider is not enrolled in Medicare.

Topic #686

Reimbursement for Crossover Claims

Professional Crossover Claims

Information is available for [DOS \(dates of service\) before April 1, 2013](#).

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

Total payment for a Medicare Part B-covered service (i.e., any amount paid by other health insurance sources, any copayment or spenddown amounts paid by the member, and any amount paid by Wisconsin Medicaid) may not exceed the Medicare-allowed amount. Therefore, Medicaid reimbursement for coinsurance or copayment of a Medicare Part B-covered service is the lesser of the following:

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

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

Reimbursement for Coinsurance or Copayment of Medicare Part B-Covered Services			
Explanation	Example		
	1	2	3
Provider's billed amount	\$120	\$120	\$120
Medicare-allowed amount	\$100	\$100	\$100
Medicaid-allowed amount (e.g., maximum allowable fee)	\$90	\$110	\$75
Medicare payment	\$80	\$80	\$80
Medicaid payment	\$10	\$20	\$0

Outpatient Hospital Crossover Claims

Detail-level information is used to calculate pricing for all outpatient hospital crossover claims and adjustments. Details that

Medicare paid in full or that Medicare denied in full will not be considered when pricing outpatient hospital crossover claims. Medicare deductibles are paid in full.

Inpatient Hospital Services

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

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

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

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

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

Topic #4977

Rendering Provider on Professional Crossover Claims

Providers are required to indicate the rendering provider on electronic and paper crossover claims when ForwardHealth service-specific policy requires a rendering provider. However, professional crossover claims received by ForwardHealth from Medicare may not have the taxonomy code of the billing provider indicated on the transaction. Medicare will not accept the 837P (837 Health Care Claim: Professional) transaction when a taxonomy code is reported in both the Billing/Pay-to Provider Loop and in the Rendering Provider Loop if the billing and rendering providers are different. For example, a transaction with a physician group indicated as the billing provider and the individual physician indicated as the rendering provider.

Providers should resubmit professional crossover claims to ForwardHealth when the taxonomy code is required to identify the billing provider and it is not indicated on the crossover claim received from Medicare. Taxonomy codes for billing and rendering providers may be required if the provider has a single NPI for multiple ForwardHealth provider enrollments. Providers should refer to the [837 companion guides](#) for information on using taxonomy codes on standard claim transactions. ForwardHealth will accept the 837P transaction when a taxonomy code is reported in both the Billing/Pay-to Provider Loop and in the Rendering Provider Loop and the billing and rendering providers are different.

This ForwardHealth requirement is inconsistent with the instructions in the 837P Implementation Guide; however, CMS (Centers

for Medicare and Medicaid Services) has acknowledged that health plans may need the billing provider taxonomy in order to accurately process claims.

Topic #770

Services Requiring Medicare Billing

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

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

If the EVS indicates Medicare Cost, the provider is required to bill the following services to the Medicare Advantage Plan before submitting claims to ForwardHealth:

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

ForwardHealth has identified [services requiring commercial health insurance billing](#).

Other Coverage Information

Topic #4940

After Reporting Discrepancies

After receiving an [Other Coverage Discrepancy Report \(F-01159 \(09/12\)\)](#), ForwardHealth confirms the information and updates the member files.

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

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

Topic #4941

Coverage Discrepancies

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

Topic #609

Insurance Disclosure Program

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

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

Topic #610

Maintaining Accurate and Current Records

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

- Insurance Disclosure program.
- Providers who submit an [Other Coverage Discrepancy Report \(F-01159 \(09/12\)\)](#) form.
- Member certifying agencies.

- Members.

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

Topic #4942

Reporting Discrepancies

Providers are encouraged to report discrepancies to ForwardHealth by submitting the [Other Coverage Discrepancy Report \(F-01159 \(09/12\)\)](#) form. Providers are asked to complete the form in the following situations:

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

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

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

Provider-Based Billing

Topic #660

Purpose of Provider-Based Billing

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

Topic #658

Questions About Provider-Based Billing

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

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

Topic #661

Receiving Notification

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

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

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

Topic #659

Responding to ForwardHealth After 120 Days

If a response is not received within 120 days, the amount originally paid by BadgerCare Plus or Wisconsin Medicaid will be withheld from future payments. This is not a final action. To receive payment after the original payment has been withheld, providers are required to submit the required documentation to the appropriate address as indicated in the following tables. For

DOS (dates of service) that are within claims submission deadlines, providers should refer to the first table. For DOS that are beyond claims submission deadlines, providers should refer to the second table.

Within Claims Submission Deadlines		
Scenario	Documentation Requirement	Submission Address
The provider discovers through the EVS (Wisconsin's Enrollment Verification System) that ForwardHealth has removed or ended the other health insurance coverage from the member's file.	A claim according to normal claims submission procedures (do <i>not</i> use the prepared provider-based billing claim).	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784
The provider discovers that the member's other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	<ul style="list-style-type: none"> An Other Coverage Discrepancy Report (F-01159 (09/12)) form. A claim according to normal claims submission procedures after verifying that the member's other coverage information has been updated by using the EVS (do <i>not</i> use the prepared provider-based billing claim). 	<p>Send the Other Coverage Discrepancy Report form to the address indicated on the form.</p> <p>Send the claim to the following address:</p> <p>ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784</p>
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	<ul style="list-style-type: none"> A claim according to normal claims submission procedures (do <i>not</i> use the prepared provider-based billing claim). The appropriate other insurance indicator. The amount received from the other health insurance source. 	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784
The other health insurance source denies the provider-based billing claim.	<ul style="list-style-type: none"> A claim according to normal claims submission procedures (do <i>not</i> use the prepared provider-based billing claim). The appropriate other insurance indicator or Medicare disclaimer code. 	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784
The commercial health insurance carrier does not respond to an initial <i>and</i> follow-up provider-based billing claim.	<ul style="list-style-type: none"> A claim according to normal claims submission procedures (do <i>not</i> use the prepared provider-based billing claim). The appropriate other insurance indicator. 	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784

Beyond Claims Submission Deadlines		
Scenario	Documentation Requirement	Submission Address
The provider discovers through the EVS that ForwardHealth has removed or ended the other health insurance coverage from the member's file.	<ul style="list-style-type: none"> A claim (do <i>not</i> use the prepared provider-based billing claim). A Timely Filing Appeals Request (F-13047 (07/12)) form according to normal timely filing appeals procedures. 	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The provider discovers that the	<ul style="list-style-type: none"> An Other Coverage Discrepancy Report form. 	Send the Other Coverage

member's other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	<ul style="list-style-type: none"> • <i>After</i> using the EVS to verify that the member's other coverage information has been updated, include both of the following: <ul style="list-style-type: none"> ◦ A claim (do <i>not</i> use the prepared provider-based billing claim.) ◦ A Timely Filing Appeals Request form according to normal timely filing appeals procedures. 	<p>Discrepancy Report form to the address indicated on the form.</p> <p>Send the timely filing appeals request to the following address:</p> <p>ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784</p>
The commercial health insurance carrier reimburses or partially reimburses the provider-based billing claim.	<ul style="list-style-type: none"> • A claim (do <i>not</i> use the prepared provider-based billing claim). • Indicate the appropriate other insurance indicator. • Indicate the amount received from the commercial insurance. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures. 	<p>ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784</p>
The other health insurance source denies the provider-based billing claim.	<ul style="list-style-type: none"> • A claim (do <i>not</i> use the prepared provider-based billing claim). • The appropriate other insurance indicator or Medicare disclaimer code. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures. • The Provider-Based Billing Summary. • Documentation of the denial, including any of the following: <ul style="list-style-type: none"> ◦ Remittance information from the other health insurance source. ◦ A written statement from the other health insurance source identifying the reason for denial. ◦ A letter from the other health insurance source indicating a policy termination date that proves that the other health insurance source paid the member. ◦ A copy of the insurance card or other documentation from the other health insurance source that indicates that the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage only. • The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary. 	<p>ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784</p>
The commercial health insurance carrier does not respond to an initial and follow-up provider-based	<ul style="list-style-type: none"> • A claim (do <i>not</i> use the prepared provider-based billing claim). • The appropriate other insurance indicator. 	<p>ForwardHealth Timely Filing Ste 50</p>

billing claim.	<ul style="list-style-type: none"> • A Timely Filing Appeals Request form according to normal timely filing appeals procedures. 	313 Blettner Blvd Madison WI 53784
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Topic #662

Responding to ForwardHealth Within 120 Days

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

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

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

Scenario	Documentation Requirement	Submission Address
The provider discovers through the EVS that ForwardHealth has removed or ended the other health insurance coverage from the member's file.	<ul style="list-style-type: none"> • The Provider-Based Billing Summary. • Indication that the EVS no longer reports the member's other coverage. 	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The provider discovers that the member's other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	<ul style="list-style-type: none"> • The Provider-Based Billing Summary. • One of the following: <ul style="list-style-type: none"> ◦ The name of the person with whom the provider spoke and the member's correct other coverage information. ◦ A printed page from an enrollment Web site containing the member's correct other coverage information. 	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	<ul style="list-style-type: none"> • The Provider-Based Billing Summary. • A copy of the remittance information received from the other health insurance source. • The DOS (date of service), other health insurance source, billed amount, and procedure code indicated on the other insurer's remittance information must match the information on the Provider-Based Billing Summary. <p><i>Note:</i> In this situation, ForwardHealth will initiate an adjustment if the amount of the other health insurance payment does not exceed the allowed amount (even though an adjustment request should not be submitted). However, providers (except nursing home and hospital providers) may issue a cash refund. Providers who choose this option should include a refund check but should not use the Claim Refund</p>	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567

	form.	
The other health insurance source denies the provider-based billing claim.	<ul style="list-style-type: none"> • The Provider-Based Billing Summary. • Documentation of the denial, including any of the following: <ul style="list-style-type: none"> ◦ Remittance information from the other health insurance source. ◦ A letter from the other health insurance source indicating a policy termination date that precedes the DOS. ◦ Documentation indicating that the other health insurance source paid the member. ◦ A copy of the insurance card or other documentation from the other health insurance source that indicates the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage. • The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary. 	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The other health insurance source fails to respond to the initial <i>and</i> follow-up provider-based billing claim.	<ul style="list-style-type: none"> • The Provider-Based Billing Summary. • Indication that no response was received by the other health insurance source. • Indication of the dates that the initial and follow-up provider-based billing claims were submitted to the other health insurance source. 	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567

Topic #663

Submitting Provider-Based Billing Claims

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

Reimbursement for Services Provided for Accident Victims

Topic #657

Billing Options

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

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

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

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

Topic #829

Points of Consideration

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

Time

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

Costs

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

Topic #826

Seeking Payment from Settlement

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

Topic #827

Submitting Claims to ForwardHealth

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

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

Covered and Noncovered Services

3

Archive Date:01/02/2014

Covered and Noncovered Services: Clozapine Management

Topic #2604

An Overview

Clozapine management is a specialized care management service that may be required to ensure the safety of members who are receiving this psychoactive medication. Clozapine management services refer to the monitoring of a member's drug intake, testing, and mental health; the drug itself is reimbursed separately.

Clozapine (Clozaril®) is reimbursed separately for outpatient and nursing home members. Clozapine management is reimbursable only for outpatient services.

Clozapine management is covered for members enrolled in Medicaid, BadgerCare Plus Standard Plan, Benchmark Plan, and Core Plan.

A member is required to have a separate order for laboratory work and a physician order for clozapine management services.

Topic #7277

Clozapine Coverage for Dual Eligibles

For dual eligibles, reimbursement for clozapine management services is available; however, clozapine is not reimbursable.

Topic #2606

Components

The following components are part of the clozapine management service and must be provided, as needed, by the physician or by a qualified professional under the general supervision of the physician:

- Ensure that the member has the required WBC (white blood cell) count and ANC (absolute neutrophil count) testing. According to FDA (Food and Drug Administration) labeling, a member must have a baseline WBC count and ANC before initiation of clozapine treatment, and a WBC count and ANC every week for the first six months while taking clozapine.

The frequency of WBC count and ANC testing may be reduced to once every two weeks for the next six months if the following criteria are met:

- The member has taken clozapine continually for six months.
- The weekly WBC count has remained stable at greater than or equal to 3,500/mm³ during that period.
- The weekly ANC has remained stable at greater than or equal to 2,000/mm³ during that period.

If, after the second six months, the member has taken clozapine continuously and the biweekly WBC count and ANC remain stable (at the previously listed levels), a member's WBC count and ANC may be tested every four weeks.

The frequency of ANC and WBC tests is determined by the prescriber and may be reimbursed by Wisconsin Medicaid as previously described.

For members who have a break in therapy, blood counts must be taken at a frequency in accordance with the rules set forth in the "black box" warning of the manufacturer's package insert.

The provider may draw the blood or transport the member to a clinic, hospital, or laboratory to have the blood drawn, if necessary. The provider may travel to the member's residence or other places in the community where the member is available to perform this service, if necessary. The provider's transportation to and from the member's home or other community location to carry out any of the required services listed here are considered part of the capitated weekly or biweekly payment for clozapine management and is not separately reimbursable. The blood test is separately reimbursable for a Medicaid-enrolled laboratory.

- Obtain the blood test results in a timely fashion.
- Ensure that abnormal blood test results are reported in a timely fashion to the provider dispensing the member's clozapine.
- Ensure that the member receives medications as scheduled and that the member stops taking medication when a blood test is abnormal, if this decision is made, and receives any physician-prescribed follow-up care to ensure that the member's physical and mental well-being is maintained.
- Make arrangements for the transition and coordination of the use of clozapine tablets and clozapine management services between different care locations.
- Monitor the member's mental status according to the care plan. The physician is responsible for ensuring that all individuals having direct contact with the member in providing clozapine management services have sufficient training and education. These individuals must be able to recognize the signs and symptoms of mental illness, the side effects from drugs used to treat mental illness, and when changes in the member's level of functioning need to be reported to a physician or registered nurse.
- Following the record keeping requirements for clozapine management.

Topic #2607

Conditions for Coverage

Physicians, physician clinics, and pharmacy providers may be separately reimbursed for clozapine management services when all of the following conditions are met:

- A physician prescribes the clozapine management services in writing if any of the components of clozapine management are provided by the physician or by individuals who are under the general supervision of a physician. Although separate prescriptions are not required for clozapine tablets and clozapine management, the clozapine management service must be identified as a separately prescribed service from the drug itself.
- The member is currently taking or has taken clozapine tablets within the past four weeks.
- The member resides in a community-based setting (excluding hospitals and nursing homes).
- The physician or qualified staff person has provided the required components of clozapine management.

BadgerCare Plus covers clozapine management services at the same frequency as the member's blood count testing. If a prescriber deems more frequent WBC (white blood cell) count and ANC (absolute neutrophil count) testing to be medically necessary *and* orders it, BadgerCare Plus will cover clozapine management at the higher frequency.

Topic #2608

Member Diagnosis

Clozapine is appropriate for members with a diagnosis of a schizophrenic disorder (ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis code between 295.10 and 295.95) *and* who have a documented history of failure with at least two psychotropic drugs. Lithium carbonate may not be one of the two failed drugs. Reasons for the

failure may include:

- No improvement in functioning level.
- Continuation of positive symptoms (hallucinations or delusions).
- Severe side effects.
- Tardive dyskinesia/dystonia.

Topic #2609

Record Keeping Requirements

The provider who submits claims for clozapine management must keep a unique record for each member for whom clozapine management is provided. This record may be a part of a larger record that is also used for other services, if the provider is also providing other services to the member. However, the clozapine management records must be clearly identified as such and must contain the following:

- A cover sheet identifying the member, including the following information:
 - Member's Medicaid identification number.
 - Member's name.
 - Member's current address.
 - Name, address, and telephone number of the primary medical provider (if different from the prescribing physician).
 - Name, address, and telephone number of the dispensing provider from whom the member is receiving clozapine tablets.
 - Address and telephone number of other locations at which the client may be receiving a blood draw on his or her own.
 - Address and telephone number where the member can often be contacted.
- A care plan indicating the manner in which the provider ensures that the covered services are provided (e.g., plan indicates where and when blood will be drawn, whether the member will pick up medications at the pharmacy or whether they will be delivered by the provider). The plan should also specify signs or symptoms that might result from side effects of the drug or other signs or symptoms related to the member's mental illness that should be reported to a qualified medical professional. The plan should indicate the health care professionals to whom oversight of the clozapine management services has been delegated and indicate how often they will be seeing the member. The plan should be reviewed every six months during the first year of clozapine use. Reviews may be reduced to once per year after the first year of use if the member is stable, as documented in the record.
- Copies of physician's prescriptions for clozapine and clozapine management.
- Copies of laboratory results of WBC (white blood cell) counts and ANC (absolute neutrophil count) testing.
- Signed and dated notes documenting all clozapine management services. Indicate date of all blood draws as well as who performed the blood draws. If the provider had to travel to provide services, indicate the travel time. Document services provided to ensure that the member received medically necessary care following an abnormal blood test results.

Physicians, physician clinics, and pharmacies providing clozapine management services must be extremely careful not to double bill BadgerCare Plus for services. This may happen when physicians provide clozapine management services during the same encounter as when they provide other ForwardHealth-allowable physician services. In these cases, the physician must document the amount of time spent on the other physician service separately from the time spent on clozapine management. Regular psychiatric medication management is not considered a part of the clozapine management services and, therefore, may be billed separately.

Topic #2610

Reimbursement Not Available

Wisconsin Medicaid does not reimburse for the following as clozapine management services:

- Clozapine management for a member not receiving clozapine, except for the first four weeks after discontinuation of the drug.
- Clozapine management for members residing in a nursing facility or hospital on the DOS (date of service).
- Care coordination or medical services not related to the member's use of clozapine.

Topic #2614

Separately Reimbursable Services

Blood Testing

The WBC (white blood cell) count and ANC (absolute neutrophil count) testing must be performed and billed by a Medicaid-enrolled laboratory to receive Wisconsin Medicaid reimbursement.

Member Transportation

Member transportation to a physician's office is reimbursed in accordance with [DHS 107.23](#), Wis. Admin. Code. NEMT (non-emergency transportation services) services for most members are provided through MTM Inc. (Medical Transportation Management Inc.), the transportation management system contracted with the DHS (Department of Health Services). Providers may be asked to verify that the member received covered services at their site on a particular date. Refer to the [NEMT service area](#) for more information.

Codes

Topic #6717

Administration Procedure Codes for Provider-Administered Drugs

For provider-administered drugs administered to members enrolled in BadgerCare Plus HMOs (health maintenance organizations), Medicaid SSI (Supplemental Security Income) HMOs, and most special MCOs (managed care organizations), the CPT (Current Procedural Terminology) administration procedure codes below should be indicated on claims submitted for reimbursement to BadgerCare Plus and Medicaid fee-for-service, not the member's MCO. Claims for administration procedure codes not indicated on the table below should be submitted to the member's MCO for reimbursement. Only services that are covered by ForwardHealth are reimbursed.

Code	Description
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
96373	intra-arterial
96374	intravenous push, single or initial substance/drug
96375	each additional sequential intravenous push of a new substance/drug
96376	each additional sequential intravenous push of the same substance/drug provided in a facility
96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion

Topic #9938

Age- and Gender-Restricted Contraceptive HCPCS Procedure Codes

Information is available for [DOS \(dates of service\) before January 1, 2013](#).

HCPCS (Healthcare Common Procedure Coding System) procedure codes and descriptions for age- and gender-restricted contraceptives are in the table below.

Contraceptives are covered for females who are 10 through 65 years of age.

Age- and Gender-Restricted Contraceptives	
Procedure Code	Description
J7300	Intrauterine copper contraceptive
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
J7303	Contraceptive supply, hormone containing vaginal ring, each
J7304	Contraceptive supply, hormone containing patch, each
J7306	Levonorgestrel (contraceptive) implant system, including implants and supplies
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies

S4993	Contraceptive pills for birth control
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Topic #4012

Cochlear Implants

Providers should indicate the following procedure codes on PA (prior authorization) requests and claims for cochlear implants. All procedure codes in this table are separately reimbursable for members residing in a nursing home. Refer to the [DME \(Durable Medical Equipment\) Index](#) for maximum allowable fees.

Cochlear Implant Hearing Devices	
Code	Description
L7510	Repair of prosthetic device, repair or replace minor parts
L8614	Cochlear device, includes all internal and external components
L8615	Headset/headpiece for use with cochlear implant device, replacement
L8616	Microphone for use with cochlear implant device, replacement
L8617	Transmitting coil for use with cochlear implant device, replacement
L8618	Transmitter cable for use with cochlear implant device, replacement
L8619	Cochlear implant, external speech processor and controller, integrated system, replacement
L8621	Zinc air battery for use with cochlear implant device, replacement, each
L8622	Alkaline battery for use with cochlear implant device, any size, replacement, each
L8623	Lithium ion battery for use with cochlear implant device speech processor; other than ear level, replacement, each
L8624	ear level, replacement, each

Replacement Parts for Cochlear Implants

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

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

Topic #4945

Physicians Required to Obtain Separate Enrollment

To be reimbursed for dispensing DME (durable medical equipment), physicians are required to obtain separate Medicaid enrollment as a [medical equipment vendor](#).

Topic #830

Diagnosis Codes

All diagnosis codes indicated on claims (and PA (prior authorization) requests when applicable) must be the most specific ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis code. Providers are responsible for keeping current with diagnosis code changes. Etiology and manifestation codes may not be used as a primary diagnosis.

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

Topic #564

Modifiers

Allowable modifiers for physician E&M (evaluation and management), medicine, and surgery services are listed in the following table.

Note: Wisconsin Medicaid accepts all valid modifiers; however, not all modifiers are allowed by Wisconsin Medicaid's claims processing system.

Modifier	Description	Notes
24	Unrelated E&M service by the same physician during a post-operative period	This modifier can be used to indicate separately identifiable procedures on the same DOS (date of service).
25	Significant, separately identifiable E&M service by the same physician on the same day of the procedure or other service	This modifier can be used to indicate separately identifiable procedures on the same DOS.
26	Professional component	Procedure codes for which modifier "26" is allowable are identified in the allowable procedure codes list .
50	Bilateral procedure	Use of modifier "50" is allowed for those procedures for which the concept is considered appropriate according to standard coding protocols and HCPCS (Healthcare Common Procedure Coding System) or CPT (Current Procedural Terminology) definitions. The physician services maximum allowable fee schedule identifies procedures in which this modifier is allowable.
54	Surgical care only	Use of modifier "54" is allowed only for cataract surgery procedure codes 66820-66821, 66830-66984 for preoperative care and surgery when post-operative care is performed by an optometrist. The surgeon is reimbursed at 90 percent of global maximum allowable fee for preoperative care and minor surgery or 80 percent for preoperative care and major surgery.

55	Postoperative management only	Use of modifier "55" is allowed only for cataract surgery procedure codes 66820-66821, 66830-66984 for postoperative care when performed by an optometrist.
62	Two surgeons	<p>This modifier can be used to indicate separately identifiable procedures on the same DOS.</p> <p>Modifier "62" should be indicated when two surgeons work together as primary surgeons performing distinct parts of a procedure, each surgeon should report his or her distinct operative work by adding modifier "62" to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedures (including add-on procedures) are performed during the same surgical session, separate codes may also be reported with modifier "62" added.</p> <p>When submitting claims for services provided by two surgeons (either on the same claim or on separate claims), modifier "62" should be entered next to the associated procedure code.</p>
76	Repeat procedure or service by same physician	This modifier can be used to indicate repeat procedures on the same DOS.
77	Repeat procedure or service by another physician	This modifier can be used to indicate repeat procedures on the same DOS.
80	Assistant surgeon	<p>Use of modifier "80" is allowed for those surgery procedures recognized as accepted medical practice.</p> <p>For a list of surgical procedure codes for which ForwardHealth reimburses assistant surgery services, refer to the "Medical-Assistant Surgery" interactive maximum allowable fee schedule.</p>
81	Minimum Assistant Surgeon	<p>Minimum surgical assistant services are identified by adding modifier "81" to the usual procedure number.</p> <p>For a list of surgical procedure codes for which ForwardHealth reimburses assistant surgery services, refer to the "Medical-Assistant Surgery" interactive maximum allowable fee schedule.</p>
82	Assistant Surgeon (when qualified resident surgeon not available)	<p>The unavailability of a qualified resident surgeon is a prerequisite for use of modifier "82" appended to the usual procedure code number(s).</p> <p>For a list of surgical procedure codes for which ForwardHealth reimburses assistant surgery services, refer to the "Medical-Assistant Surgery" interactive maximum allowable fee schedule.</p>
AQ	Physician providing service in a HPSA	Providers receive enhanced reimbursement when services are performed in a HPSA (Health Professional Shortage Area) .
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	For a list of surgical procedure codes for which ForwardHealth reimburses assistant surgery services, refer to the "Medical-Assistant Surgery" interactive maximum allowable fee schedule.
TC	Technical component	Procedure codes for which modifier "TC" is allowable are identified in the allowable procedure codes list .
	Obstetrical treatment/	Providers are required to use modifier "TH" with procedure codes 99204 and 99213 only when those codes are used to indicate the first three antepartum care visits.

TH	services, prenatal or postpartum	Providers are required to use both modifiers "TH" and "AQ" when these prenatal services are HPSA eligible.
TJ	Program group, child and/or adolescent	Providers may use modifier "TJ" with procedure codes 99201-99215 and 99281-99285 only for members 18 years of age and younger. Providers should not bill the HPSA modifier with modifier "TJ."
U1	Nonelective Cesarean Section (locally defined)	Providers may use modifier "U1" with procedure codes 59510, 59514, and 59515 to indicate nonelective cesarean sections.
UD	Clozapine Management (locally defined)	Providers may use modifier "UD" with procedure code H0034 only.

Topic #565

Place of Service Codes

Allowable POS (place of service) codes for physician E&M (evaluation and management), medicine, and surgery services are listed in the following table.

POS Code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
13	Assisted Living Facility
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room — Hospital
24	Ambulatory Surgical Center
25	Birthing Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance — Land
42	Ambulance — Air or Water
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility

54	Facilities for Developmental Disabilities
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic

Topic #566

Procedure Codes

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

Topic #15297

Procedures Reimbursable Only as Inpatient Hospital or Ambulatory Surgery Center Services

Effective for DOS (dates of service) on and after April 1, 2013, certain surgical procedures may be reimbursed only when performed in an inpatient hospital, indicated by POS (place of service) code 21 (Inpatient Hospital), or an ASC (ambulatory surgery center), indicated by POS 24 (Ambulatory Surgical Center).

Providers billing these services on professional claims (i.e., the 837P (837 Health Care Claim: Professional) transaction or the 1500 Health Care Claim Form) are affected by this policy.

The following table lists services that may be reimbursed only when performed in an inpatient hospital. This list may be periodically updated.

21179	21180	21182	21183	22010	22015	22116	22216	22226	22318
22319	22328	22532	22533	22534	22551	22552	22633	22634	22804
22808	22841	22843	22844	22847	22848	32096	32097	32501	32503
32504	32505	32506	32507	32666	32667	32668	32669	32671	32674
33031	33140	33250	33251	33257	33258	33259	33261	33410	33416
33426	33427	33500	33507	33530	33548	33620	33622	33768	33774
33776	33777	33778	33779	33780	33813	33814	33852	33864	33880
33881	33883	33884	33889	33891	33916	33924	33925	33926	33968
33979	33980	33981	33982	34833	34834	34900	35633	39560	39561
43314	43327	44126	44127	44128	44132	44135	44202	44203	44204
44205	44210	44211	44212	44227	45126	45395	45397	47361	47362

49203	49204	49205	50250	50545	50546	50547	50548	57111	57112
58146	58293	58953	58956	59525	60650	61316	61517	61697	61698
62148	62161	62162	62163	62164	62165	92970	93463	99190	99191
99192	99356	99357	99460	99462	99463	99468	99469	99471	99472
99475	99476	99477	99478	99479	99480				

The following table lists services that may be reimbursed only when performed in an inpatient hospital or ASC. The list may be periodically updated.

01990	19305	19306	19361	19368	20661	20802	20805	20808	20816
20824	20955	20956	20962	20969	20970	21154	21155	21159	21160
21188	21194	21247	21268	21344	21347	21348	21366	21423	21431
21432	21433	21435	21436	21510	21615	21616	21620	21630	21632
21705	21740	21750	21810	22110	22112	22114	22210	22212	22214
22220	22224	22325	22326	22327	22548	22556	22590	22595	22610
22800	22802	22810	22812	22818	22819	22842	22849	22852	22857
23200	23210	23220	23332	23900	23920	24900	24920	24930	24940
25900	25905	25915	25920	25927	26551	26553	27030	27036	27054
27070	27071	27075	27076	27077	27078	27090	27091	27120	27122
27125	27132	27134	27137	27138	27140	27146	27147	27151	27156
27158	27161	27165	27170	27175	27177	27178	27181	27185	27187
27215	27217	27218	27222	27226	27227	27228	27232	27236	27240
27244	27245	27248	27253	27254	27258	27259	27280	27282	27284
27286	27290	27295	27365	27445	27448	27450	27454	27465	27466
27468	27470	27472	27485	27486	27487	27488	27495	27506	27507
27511	27513	27514	27519	27556	27557	27558	27580	27590	27591
27592	27596	27598	27645	27646	27702	27703	27712	27725	27727
27880	27881	27882	27888	28800	31230	31360	31365	31367	31368
31370	31380	31382	31390	31395	31584	31587	31725	31760	31766
31770	31775	31780	31781	31786	31800	31805	32035	32036	32100
32110	32120	32124	32140	32141	32150	32151	32160	32200	32215
32220	32225	32310	32320	32440	32442	32445	32480	32482	32484
32486	32488	32540	32652	32663	32665	32800	32810	32815	32820
32850	32851	32852	32853	32854	32855	32856	32900	32905	32906
32940	32997	33015	33020	33025	33030	33050	33120	33130	33141
33202	33203	33236	33237	33238	33243	33254	33255	33256	33265

33266	33300	33305	33310	33315	33320	33322	33330	33332	33335
33400	33401	33403	33404	33405	33406	33411	33412	33413	33414
33415	33417	33420	33422	33425	33430	33460	33463	33464	33465
33468	33470	33471	33472	33474	33475	33476	33478	33496	33501
33502	33503	33504	33505	33506	33510	33511	33512	33513	33514
33516	33517	33518	33519	33521	33522	33523	33533	33534	33535
33536	33542	33545	33572	33600	33602	33606	33608	33610	33611
33612	33615	33617	33619	33641	33645	33647	33660	33665	33670
33675	33676	33677	33681	33684	33688	33690	33692	33694	33697
33702	33710	33720	33722	33724	33726	33730	33732	33735	33736
33737	33750	33755	33764	33766	33767	33770	33771	33786	33788
33800	33802	33803	33820	33822	33824	33840	33845	33851	33853
33860	33863	33870	33875	33877	33910	33915	33917	33920	33922
33930	33933	33935	33940	33944	33945	33960	33961	33967	33970
33971	33973	33974	33975	33976	33977	33978	34001	34051	34151
34401	34451	34502	34800	34802	34803	34804	34805	34806	34808
34812	34820	34825	34826	34830	34831	34832	35001	35002	35013
35021	35022	35081	35082	35091	35092	35102	35103	35111	35112
35121	35122	35131	35132	35141	35142	35151	35152	35182	35189
35211	35216	35221	35241	35246	35251	35271	35276	35281	35301
35302	35311	35331	35341	35351	35355	35361	35363	35371	35372
35390	35400	35501	35506	35508	35509	35511	35515	35516	35518
35521	35526	35531	35533	35536	35538	35539	35540	35556	35558
35560	35563	35565	35566	35571	35583	35585	35587	35600	35601
35606	35612	35621	35623	35626	35631	35636	35637	35638	35642
35645	35646	35650	35654	35656	35661	35663	35665	35666	35671
35681	35682	35683	35691	35693	35694	35695	35697	35700	35800
35840	35870	35905	35907	36660	36822	37140	37160	37180	37181
37182	37616	37617	37660	37788	38100	38101	38102	38115	38381
38382	38562	38564	38724	38747	38765	38770	38780	39200	39220
39501	39503	39540	39541	41135	41140	41145	41150	41153	41155
42426	42845	42894	42961	42971	43045	43101	43107	43108	43112
43113	43116	43117	43121	43122	43123	43124	43310	43312	43325
43330	43331	43340	43341	43350	43351	43352	43360	43361	43400
43405	43415	43425	43460	43496	43501	43502	43605	43610	43611

43620	43621	43622	43631	43632	43633	43634	43640	43641	43800
43810	43820	43825	43832	43840	43846	43847	43850	43855	43860
43865	43881	43882	44010	44015	44021	44025	44111	44120	44121
44139	44140	44144	44145	44146	44147	44150	44151	44155	44156
44157	44158	44160	44300	44310	44314	44316	44320	44322	44345
44604	44605	44625	44626	44660	44661	44680	44700	44720	44721
44800	44960	45110	45111	45112	45114	45116	45119	45120	45121
45130	45135	45540	45550	45563	45805	45825	46730	46735	46742
46744	46746	46748	47010	47100	47120	47122	47125	47130	47133
47135	47140	47142	47143	47144	47145	47146	47147	47300	47350
47360	47380	47381	47400	47420	47425	47460	47480	47550	47600
47605	47610	47612	47620	47700	47701	47711	47712	47715	47720
47721	47740	47741	47760	47765	47780	47785	47800	47900	48020
48100	48105	48120	48145	48146	48148	48150	48152	48153	48154
48155	48400	48500	48520	48540	48545	48547	48548	48551	48554
48556	49020	49040	49060	49062	49428	49605	49611	49905	50010
50040	50045	50060	50065	50070	50075	50100	50120	50125	50130
50135	50205	50220	50225	50234	50236	50240	50280	50290	50300
50320	50323	50325	50327	50328	50340	50360	50365	50370	50380
50400	50405	50500	50520	50540	50600	50605	50610	50620	50630
50650	50660	50700	50715	50722	50725	50740	50750	50760	50770
50780	50782	50783	50785	50800	50810	50815	50820	50825	50830
50840	50860	50900	50920	50930	50940	51525	51530	51550	51555
51565	51570	51575	51580	51585	51590	51595	51596	51597	51800
51820	51841	51865	51900	51920	51925	51940	51960	51980	54125
54130	55801	55810	55812	55815	55821	55831	55840	55845	56630
56631	56632	56633	56634	56637	56640	57110	57270	57280	57305
57307	57308	57311	57531	57540	57545	58140	58150	58152	58180
58200	58210	58240	58275	58280	58285	58548	58605	58611	58822
58825	58940	58943	58950	58951	58952	58954	58957	58958	59130
59136	59140	59350	59514	59620	59852	59855	59856	60254	60270
60505	60521	60522	60540	60545	60600	60605	61105	61107	61108
61120	61140	61150	61151	61154	61156	61210	61250	61304	61305
61312	61313	61314	61315	61320	61321	61333	61340	61343	61345
61440	61450	61458	61460	61480	61490	61500	61501	61510	61512

61514	61516	61518	61519	61520	61521	61522	61524	61526	61530
61531	61533	61534	61535	61536	61537	61538	61539	61540	61541
61542	61543	61544	61545	61546	61548	61550	61552	61556	61557
61558	61559	61563	61564	61566	61567	61570	61571	61575	61580
61581	61582	61583	61584	61585	61586	61590	61591	61592	61595
61596	61597	61598	61600	61601	61605	61606	61607	61608	61609
61610	61612	61613	61615	61616	61618	61619	61680	61682	61684
61686	61690	61692	61700	61702	61703	61705	61708	61710	61711
61735	61750	61751	61760	61860	61863	61864	61867	61868	61870
62005	62010	62100	62116	62117	62120	62121	62140	62141	62142
62143	62145	62146	62147	62180	62190	62192	62200	62201	62220
62223	62256	62258	63050	63051	63077	63078	63081	63082	63085
63086	63087	63088	63090	63091	63101	63102	63103	63170	63172
63173	63180	63182	63185	63190	63194	63195	63196	63197	63200
63250	63251	63252	63265	63266	63268	63270	63271	63272	63273
63275	63276	63277	63278	63280	63281	63282	63283	63285	63286
63287	63290	63295	63300	63301	63302	63303	63304	63305	63306
63308	63700	63702	63704	63706	63709	63710	63740	64752	64755
64760	64809	65273	69155	69535	69554	69950	92975	92992	92993

Topic #13817

Restorative Plastic Surgery and Procedures

Generally, restorative plastic surgery and procedures are defined as procedures that are done to improve appearance and, thus, generally do not meet the definition of medical necessity as defined under [DHS 101.03\(96m\)](#), Wis. Admin. Code. In some cases, however, restorative plastic surgery and procedures are considered medically necessary.

Correction of congenital defects and birth abnormalities and other significant cosmetic defects in children 8 years of age and younger are considered to be medically necessary, but do require PA (prior authorization).

Reconstruction after surgery for breast cancer is considered medically necessary and does not require PA.

All [restorative plastic surgery and procedures](#) require PA with the exception of reconstruction after surgery for breast cancer. Restorative plastic surgeries and procedures that do not meet the PA approval criteria are considered noncovered. Any charges related to the noncovered restorative plastic surgery and procedures will not be reimbursed.

The following table lists allowable CPT (Current Procedural Terminology) procedure codes for restorative plastic surgery and procedures. All of the procedure codes listed in the table require prior authorization.

Surgery

Service	CPT Procedure Code(s)/Service Definitions
Integumentary System	11200-11201 (skin tags)
	11300-11313 (skin lesion shave)
	11400-11446 (benign lesion removal)
	11920-11922 (tattoos)
	11950-11954 (filling injection)
	15780-15793 (dermabrasion, peels)
	15824-15829 (face lift)
	17106-17111 (benign skin lesions)
	19316 (mastopexy)
	19324-19396 (breast reconstruction without cancer diagnosis)
Musculoskeletal System	*21083 (palatal lift prosthesis)
	*21087(nasal prosthesis)
	*21120-21123 (genioplasty)
	21137 (forehead reduction)
	*21270 (malar augmentation with prosthetic material)
	21280-21282 (canthopexy, eyelid)
Respiratory System	30120 (rhinophyma)
	30400-30450 (rhinoplasty)
Ocular System	67900-67901 (brow lift)
	67903-67909 (ptosis surgery)

* Prior authorization is required to process claims for durable medical equipment.

Topic #643

Unlisted Procedure Codes

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

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

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

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

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

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

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

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

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

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

Unlisted Codes That Do Not Require Prior Authorization

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

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

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

How to Submit Claims and Related Documentation

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

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

- Upload claim attachments via the secure Provider area of the Portal.

Topic #13777

Vagus Nerve Stimulators

The following table lists allowable CPT (Current Procedural Terminology) procedure codes for [VNS \(vagus nerve stimulator\)](#) implant surgery. All of the procedure codes listed in the table require prior authorization.

Vagus Nerve Stimulator Implant Surgery Procedure Codes	
Code	Description
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
61886	with connection to 2 or more electrode arrays
61888	Revision or removal of cranial neurostimulator pulse generator or receiver
64553	Percutaneous implantation of neurostimulator electrode array; cranial nerve
64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator
64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator
95974	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour
95975	complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

Covered Services and Requirements

Topic #646

A Comprehensive Overview

Physician services covered by Wisconsin Medicaid include the following:

- Diagnostic services.
- Palliative services.
- Preventive services.
- Rehabilitative services.
- Therapeutic services.

Services performed by physician services providers (i.e., physicians, physician assistants, nurse practitioners, and nurse midwives) must be within their legal scope of practice.

Topic #9939

Alpha Hydroxyprogesterone (17P) Caproate Compound Injection

The 17P (alpha hydroxyprogesterone caproate) compound injection is a covered service and is reimbursed fee-for-service for members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, and Medicaid, including members enrolled in state-contracted HMOs (health maintenance organizations). The 17P compound must be injected by a medical professional. Members may not self-administer the 17P injection.

Clinical Criteria

The following is clinical criteria for coverage of the 17P compound injection:

- The member must be pregnant with a singleton pregnancy.
- The member must have had a previous pre-term delivery (i.e., a spontaneous birth before 37 weeks gestation).
- The 17P injection must be initiated between week 16 to week 20 of gestation and continue through 37 weeks gestation or delivery, whichever is first.
- The member must have a diagnosis of V23.41 (Pregnancy with history of preterm labor.)

Attestation to Administer Alpha Hydroxyprogesterone (17P) Caproate Injections

The [Attestation to Administer Alpha Hydroxyprogesterone \(17P\) Caproate Injections \(F-00286 \(11/11\)\)](#) must be completed prior to giving the first injection. The completed Attestation to Administer Alpha Hydroxyprogesterone Caproate (17P) Compound Injection must be kept in the member's medical record.

To be reimbursed for the 17P compound injection, the following must be indicated on the claim according to the completion instructions for the 1500 Health Insurance Claim Form:

- A quantity of 250 mg.
- Procedure code J1725 (Injection, hydroxyprogesterone caproate, 1 mg).
- The NDC and description from the bulk powder used to compound the 17P injection.

The 17P compound injection is a diagnosis-restricted drug. Diagnosis code V23.41 (Pregnancy with history of pre-term labor) is the only diagnosis code that is allowable on claims for the 17P compound injection. Claims with other diagnosis codes indicated will be denied.

Reimbursement

The maximum allowable rate for the 17P compound injection is \$25.00 per 250 mg injection, which does not include reimbursement for the administration of the drug.

Providers may be reimbursed for the administration of the 17P compound injection by indicating procedure code 96372 (Therapeutic, prophylactic, or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular) on the claim.

The rate for administering the 17P compound injection is \$3.31.

Topic #9417

Basic Plan Covered Services and Limitations

The following medical services are covered under the BadgerCare Plus Basic Plan:

- Primary and preventive care.
- Diagnostic, surgical, and medicine services.
- Laboratory and radiology services.

Topic #9438

Service Limitations

Certain visits are subject to a combined limit of 10 visits per enrollment year. The combined 10-visit limit applies to certain visits provided by the following providers:

- Chiropractors.
- Nurse practitioners.
- Optometrists.
- Physicians (including psychiatrists and ophthalmologists).
- Physician assistants.
- Podiatrists.

The following procedure codes count toward the 10-visit limit:

E&M (evaluation and management) Codes

- 99201-99215.
- 99241-99245.
- 99304-99350.
- 99385-99499.

Chiropractic Codes

- 98940-98942.

Health and Behavior Assessment/Intervention Codes

- 96150-96154.

Psychiatric Codes

- 90785.
- 90845.
- 90847.
- 90853.
- 90875-90880.

Vision Codes

- 92002-92014.

Visits will not count toward the 10-visit limit when provided in the following POS (place of service):

- Inpatient hospital (POS 21).
- Outpatient hospital (POS 22).
- Emergency room — hospital (POS 23).
- Ambulatory surgery center (POS 24).

Topic #9317

Basic Plan Enrollment Year

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

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

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

Topic #4342

Benchmark Plan Covered Services

Physician services covered under the BadgerCare Plus Benchmark Plan are the same as those covered under the BadgerCare Plus Standard Plan with the exception of surgeries for cochlear implants and bone-anchored hearing devices. Surgeries for cochlear implants and bone-anchored hearing devices were not covered under the Benchmark Plan prior to August 1, 2010. Effective August 1, 2010, surgeries for cochlear implants and bone-anchored hearing aids are covered under the BadgerCare Plus Benchmark Plan for members 17 years of age and younger.

Topic #13717

Bone-Anchored Hearing Aids

Bone-anchored hearing aids and surgeries are covered under:

- The BadgerCare Plus Standard Plan.
- The BadgerCare Plus Benchmark Plan for members 17 years of age and younger.
- Wisconsin Medicaid.

Rendering Surgeon Required to Obtain Prior Authorization

The rendering surgeon is required to obtain PA (prior authorization) from ForwardHealth for [bone-anchored hearing aid surgeries](#). ForwardHealth will deny claims for services and equipment relating to the surgery unless there is a PA on file from the rendering surgeon for the surgery.

Separate Reimbursement

ForwardHealth separately reimburses for bone-anchored hearing aids when the implant surgery is performed in an ASC (ambulatory surgery center) or outpatient hospital and there is a PA on file from the rendering surgeon.

Providers (such as bone-anchored hearing aid manufacturers, outpatient hospitals, ASCs, or the rendering surgeon) are required to obtain separate Medicaid enrollment as a DME (durable medical equipment) provider before billing for the bone-anchored hearing aids.

A separate PA request is not required for reimbursement of the bone-anchored hearing aid. However, ForwardHealth will verify that the rendering surgeon's PA request for the implant surgery was approved before reimbursing the claim for the bone-anchored hearing aid. ForwardHealth will deny any claim for the bone-anchored hearing aid if an approved PA request from the rendering surgeon is not on file.

If a member uses a processor and headband rather than the implanted device, providers are required to obtain PA for the processor and headband equipment.

Hearing Aid Repairs and Replacements

DME providers should use procedure code L7510 (Repair of prosthetic device, repair or replace minor parts) when billing for repairs of and replacement parts for bone-anchored hearing aids.

PA is required if the total repair (procedure code L7510) exceeds \$150.00. PA is required for the replacement parts if the part being replaced has not exceeded its life expectancy.

Wisconsin Medicaid assigns "U" modifiers to multiple items listed on PA requests to indicate separate approval of DME items (i.e., accessories).

Note: Audiologists and speech and hearing clinics, as well as DME providers, may submit PA requests and bill for replacement parts and accessories.

Topic #15757

Botulinum Toxins

There are currently four botulinum toxin products commercially available in the United States:

- OnabotulinumtoxinA.
- Rimabotulinumtoxin.
- AbobotulinumtoxinA.
- IncobotulinumtoxinA.

Each preparation has distinct pharmacological and clinical profiles.

Dosing patterns are specific to the preparation of neurotoxin and are very different between different serotypes. Failure to recognize the unique characteristics of each formulation of botulinum toxin can lead to undesired patient outcomes. It is expected that prescribers will be familiar with and experienced in the use of these agents and will use evidence-based medicine to select the appropriate drug and dose regimen for each patient condition.

All botulinum toxin products are diagnosis-restricted drugs. Botulinum toxins are covered without PA (prior authorization) for any of the diagnoses listed on the [Diagnosis Code-Restricted Physician-Administered Drugs data table](#). The table lists ForwardHealth-approved diagnoses with their corresponding ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis codes. Uses of botulinum toxins for diagnoses not on the table [require submission of a PA request](#).

Topic #771

Certificate of Need for Transportation

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

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

If a member meets the criteria, a physician, physician assistant, nurse practitioner, or nurse midwife should complete a [Certification of Need for Specialized Medical Vehicle Transportation \(F-1197 \(06/09\)\)](#) form.

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

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

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

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

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

Topic #2000

Cochlear Implant Surgeries

The rendering provider is required to obtain PA (prior authorization) for cochlear implant surgeries. ForwardHealth will deny claims for services relating to the surgery unless there is an approved PA request on file from the rendering surgeon for the surgery. Surgeries for cochlear implants are covered under the BadgerCare Plus Benchmark Plan for members 17 years of age and younger.

A provider (i.e., surgeon, ASC (ambulatory surgery center)) may receive separate reimbursement for the device if the surgery is performed in an outpatient hospital or ASC *and* the provider is Medicaid-enrolled as a DME (durable medical equipment) provider.

Topic #9937

Contraceptives

Age and gender restrictions and quantity limits for certain contraceptives apply to members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, Medicaid, and Family Planning Only Services.

Age and Gender Restrictions

[Age and gender restrictions](#) apply to certain contraceptives.

Contraceptives are covered for females who are 10 through 65 years of age.

Quantity Limits

[Quantity limits](#) apply to certain contraceptives.

Claims that exceed the quantity limit are denied with an [EOB](#) (Explanation of Benefits) code.

Providers are encouraged to dispense up to a three-month supply of contraceptives, for which a quantity limit applies. However, members should be stabilized on the drug for at least 90 days. For drugs required to be dispensed in a three-month supply, once a member has been stabilized on a drug as evidenced by use of the same drug strength and dosage form for 90 days of the past 120 days, refills of the same drug strength and dosage form must be dispensed in a three-month supply. If the member previously has been dispensed a three-month supply of a drug of the same strength and dosage form, a three-month supply must be dispensed.

Duplicate Claims

Claims are denied as duplicate claims if a claim for the same contraceptive was reimbursed by ForwardHealth and the quantity allowed on the initial claim and the quantity billed on the current claim together exceed the allowed quantity limit.

If a claim is denied as a duplicate, and the member meets one of the following criteria, pharmacy providers should resubmit the claim and a completed [Written Correspondence Inquiry \(F-01170 \(07/12\)\)](#) form with an explanation to ForwardHealth. Examples of when duplicate claims will be reimbursed by ForwardHealth include, but are not limited to, the following:

- If the member has an appropriate medical need (e.g., the member's medications were lost or stolen, the member has requested a vacation supply).

- If the member experienced a medical problem while taking one contraceptive and was switched to another contraceptive.
- If the prescriber changed the directions for administration of the drug and did not inform the pharmacy provider.

Topic #8559

Core Plan Comprehensive Examination Requirement for Members

In order to remain enrolled in the BadgerCare Plus Core Plan, members must have a comprehensive exam conducted by a provider within the first year of enrollment. Refer to [a list of CPT \(Current Procedural Terminology\) codes](#) that satisfy this requirement. Providers should work with their state-contracted health plan to meet state reporting requirements for this service. If the provider does not report the exam or if the member does not have an exam, the member may not re-enroll for the Core Plan.

Comprehensive Examination Requirement Procedure Codes for BadgerCare Plus Core Plan

The following table lists *Current Procedural Terminology* (CPT) procedure codes that satisfy the comprehensive examination requirement under the BadgerCare Plus Core Plan for dates of service on and after January 1, 2009.

Procedure Code	Description
99203	Office or other outpatient visit: evaluation and management of new patient: Detailed history/examination and medical decision making of low complexity (30 min)
99204	Office or other outpatient visit for the evaluation and management of a new patient: Comprehensive history/examination and medical decision making of moderate complexity (45 min)
99205	Office or other outpatient visit for the evaluation and management of a new patient: Comprehensive history/examination and medical decision making of high complexity (60 min)
99214	Office or other outpatient visit for the evaluation and management of an established patient: Requires two of the following three: Detailed history, detailed examination, and medical decision making of moderate complexity (25 min)
99215	Office or other outpatient visit for the evaluation and management of an established patient: Requires two of the following three: Comprehensive history, comprehensive examination, and medical decision making of high complexity (40 min)
99218	Initial observation care, per day, for the evaluation and management of a patient: Requires these 3 key components: a detailed or comprehensive history, a detailed or comprehensive examination, and medical decision making that is straightforward or of low complexity. Usually, the problem(s) requiring admission to "observation status" are of low severity.
99219	Initial observation care, per day, for the evaluation and management of a patient: Requires these 3 key components: a comprehensive history, a comprehensive examination, and medical decision making of moderate complexity. Usually, the problem(s) requiring admission to "observation status" are of moderate severity.
99220	Initial observation care, per day, for the evaluation and management of a patient: Requires these 3 key components: a comprehensive history, a comprehensive examination, and medical decision making of high complexity. Usually, the problem(s) requiring admission to "observation status" are of high severity.
99221	Initial hospital care, per day, for the evaluation and management of a patient: Detailed or comprehensive history/examination and medical decision making that is straightforward or of low complexity (30 min)
99222	Initial hospital care, per day, for the evaluation and management of a patient: Comprehensive history/examination and medical decision making of moderate complexity (50 min)

99223	Initial hospital care, per day, for the evaluation and management of a patient: Comprehensive history/examination and medical decision making of a high complexity (70 min)
99234	Observation or inpatient hospital care for the evaluation and management of a patient: Detailed or comprehensive history/examination and medical decision making that is straightforward or of low complexity
99235	Observation or inpatient hospital care for the evaluation and management of a patient: Comprehensive history/examination and medical decision making of moderate complexity
99236	Observation or inpatient hospital care for the evaluation and management of a patient: Comprehensive history/examination and medical decision making of a high complexity.
99243	Office consultation for a new or established patient: Detailed history/examination and medical decision making of low complexity (40 min)
99244	Office consultation for a new or established patient: Comprehensive history/examination and medical decision making of moderate complexity (60 min)
99245	Office consultation for a new or established patient: Comprehensive history/examination and medical decision making of high complexity (80 min)
99253	Inpatient consultation for a new or established patient: Detailed history/examination and medical decision making of low complexity (55 min)
99254	Inpatient consultation for a new or established patient: Comprehensive history/examination and medical decision making of moderate complexity (80 min)
99255	Inpatient consultation for a new or established patient: Comprehensive history/examination and medical decision making of high complexity (110 min)
99284	Emergency department visit for the evaluation and management of a patient: Requires these 3 key components: a detailed history, a detailed examination, and medical decision making of moderate complexity.
99285	Emergency department visit for the evaluation and management of a patient: Requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: a comprehensive history, a comprehensive examination, and medical decision making of high complexity. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99326	Domiciliary or rest home visit for the evaluation and management of a new patient: Requires these 3 key components: a detailed history, a detailed examination, and medical decision making of moderate complexity (45 min).
99327	Domiciliary or rest home visit for the evaluation and management of a new patient: Requires these 3 key components: a comprehensive history, a comprehensive examination, and medical decision making of moderate complexity (60 min).
99328	Domiciliary or rest home visit for the evaluation and management of a new patient: Requires these 3 key components: a comprehensive history, comprehensive examination, and medical decision making of high complexity (75 min).

99336	Domiciliary or rest home visit for the evaluation and management of an established patient: Requires at least two of the following three key components: detailed interval history, detailed examination, and medical decision making of moderate complexity (40 min).
99337	Domiciliary or rest home visit for the evaluation and management of an established patient: Requires two of the following three key components: comprehensive interval history, comprehensive examination, and medical decision making of moderate to high complexity (60 min)
99343	Home visit for the evaluation and management of a new patient: Detailed history/examination, medical decision making of moderate complexity (45 min)
99344	Home visit for the evaluation and management of a new patient: Comprehensive history/examination, medical decision making of moderate complexity (60 min)
99345	Home visit for the evaluation and management of a new patient: Comprehensive history/examination, medical decision making of high complexity (75 min)
99349	Home visit for the evaluation and management of an established patient: Requires two of the following three key components: Detailed interval history, detailed examination, and medical decision making of moderate complexity (40 min)
99350	Home visit for the evaluation and management of an established patient: Requires two of the following three key components: Comprehensive interval history, comprehensive examination, and medical decision making of moderate to high complexity (60 min)
99385	Initial comprehensive preventive medicine: evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
99386	40-64 years
99395	Periodic comprehensive preventive medicine: reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
99396	40-64 years

Topic #5537

Core Plan Covered Family Planning-Related Services

BadgerCare Plus Core Plan Only Members

Family planning services are not covered under the BadgerCare Plus Core Plan. However, physician services that could be considered family planning services are covered under the Core Plan. These services are subject to the same copayment and other policies as other physician services. If the member is enrolled in an HMO (health maintenance organization), services must be provided through the member's HMO network.

Members Enrolled in BadgerCare Plus Core Plan and Family Planning Only Services

Eligible Core Plan members are given the opportunity to enroll in Family Planning Only Services also. Members enrolled in both the Core Plan and Family Planning Only Services are eligible for all the services covered under each of these plans. These members may receive family planning services from a family planning clinic or from any other health care provider allowed under

BadgerCare Plus. Services covered under Family Planning Only Services are reimbursed on a fee-for-service basis, regardless of HMO enrollment.

If providers submit claims to the BadgerCare Plus HMO for family planning-related physician services, the HMO is required to cover the service as a physician service under the Core Plan. Policies applicable to physician services apply. For Core Plan members who are also enrolled in Family Planning Only Services, providers are encouraged to submit family planning-related claims to BadgerCare Plus fee-for-service to ensure they are covered under Family Planning Only Services.

Topic #5577

Core Plan Covered Services

Physician services covered under the BadgerCare Plus Core Plan are the same as those covered under the BadgerCare Plus Standard Plan with the exception of surgeries for cochlear implants and bone-anchored hearing devices. Surgeries for cochlear implants and bone-anchored hearing devices are not covered under the Core Plan.

Mental Health/Substance Abuse Services

Only mental health services provided by psychiatrists are covered under the Core Plan. For substance abuse services, only physician services are covered. Clozapine management is a covered service under the Core Plan.

Topic #8217

Core Plan Health Care Education Benefit

Health care education on patient self-management for members diagnosed with asthma, diabetes, or hypertension is covered under the BadgerCare Plus Core Plan.

Health care education on patient self management is crucial to provide members with information to effectively manage their illness and avoid complications that result in an emergency room visit or hospitalization. This benefit is available to Core Plan members of any age who are diagnosed with asthma, diabetes, or hypertension. Education on patient self management may be appropriate in the following scenarios:

- A member whose condition is unstable or exacerbated due to poor self-management of his or her illness.
- A member whose condition is compounded by an associated condition (e.g., a member with diabetes may also be diagnosed with hypertension).
- A member with a learning disability or a diagnosis of a mental health condition.
- A member who is newly diagnosed with asthma, diabetes, or hypertension.

Core Plan members enrolled in an HMO (health maintenance organization) are required to receive the benefit through the HMO.

Health Care Education

A physician, physician assistant, or nurse practitioner is required to identify the need, in writing, for education on patient self management, and a non-physician health care professional is required to provide the education. The education must be tailored to the member's chronic condition(s) and, at a minimum, include the following information:

- A description of the disease and the disease progression.
- Importance of medication management and adherence.
- Risk factors associated with the illness.

- Warning signs and symptoms of illness exacerbation.
- Recommendations of when to contact a health care provider.

To be a covered service, the education must be provided in an individual or group setting and adhere to the following guidelines:

- Conducted in person. Telephone consultations will not be covered.
- Information must be pursuant to the patient's plan of care.
- Services must surpass the level of care normally provided during a standard [E&M \(evaluation and management\)](#) visit.

Requirements for Individuals Providing the Health Care Education

Health care education on patient self management must be provided by a physician assistant, nurse practitioner, or an [ancillary provider](#) as in the following examples:

- Certified asthma educators.
- Certified health educators.
- Certified diabetes educators.
- Registered dietitians.
- Respiratory therapists.
- Staff nurses.

The ancillary provider is required to be a licensed, certified, or registered provider who is qualified to provide education. Education provided by an ancillary provider must be conducted under the direct, immediate, [on site](#) supervision of a physician, physician assistant, or nurse practitioner.

Billing for Health Care Education

Since ancillary providers are not enrolled in Wisconsin Medicaid, claims for these services provided by ancillary providers are required to be submitted under the supervising provider's NPI (National Provider Identifier) using the appropriate code for the service. Health care education services may be billed on the same DOS (date of service) as an E&M visit.

Allowable Procedure Codes

The benefit corresponds to the CPT (Current Procedural Terminology) codes in the following table.

Code	Description
98960	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient [could include caregiver/family] each 30 minutes; individual patient
98961	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient [could include caregiver/family] each 30 minutes; 2-4 patients
98962	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient [could include caregiver/family] each 30 minutes; 5-8 patients

By definition, the allowable procedure codes may not be reimbursed if rendered by a physician.

Note: These procedure codes may not be reimbursed with other self-management training procedure codes when billed on the same DOS for the same member.

All patients diagnosed with a chronic condition in the group should be included in the total patient count, regardless of whether or not they are enrolled in the Core Plan. Caregivers should not be included in the total patient count. Core Plan members in groups in excess of eight patients will not be covered.

Coverage Limitations

Each unit of health care education is equal to 30 minutes. Eight units (four hours) are allowed per member, per enrollment year.

Allowable Diagnosis Codes

In order for health education services to be reimbursable, the member must have one or more diagnoses relating to asthma, diabetes, or hypertension as listed below.

Asthma

- 428.1 (Left heart failure [cardiac asthma]).
- 493.0 — 493.9 (Asthma).
- 500 (Coal workers' pneumoconiosis).
- 507.8 (Pneumonitis; due to other solids and liquids).
- 518.3 (Pulmonary eosinophilia).

Diabetes

- 249.00 — 249.91 (Secondary diabetes mellitus).
- 250.00 — 250.93 (Diabetes mellitus).

Hypertension

- 401.0 — 405.99 (Hypertensive disease).
- 416.0 (Primary pulmonary hypertension).
- 416.8 (Other chronic pulmonary heart diseases).
- 459.30 — 459.33 (Chronic venous hypertension [idiopathic]).
- 459.39 (Chronic venous hypertension with other complication).

Note: Diagnosis codes are subject to change. Providers are required to indicate the most specific and current diagnosis code on claims.

Code	Description
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
99	Other Place of Service

Providers are reminded of the on-site requirements when health care education is provided by an ancillary provider.

Prior Authorization

Health care education on patient self-management covered under the Core Plan does not require PA (prior authorization).

Copayments

Health care education on patient self-management is not subject to copayment under the Core Plan.

Reimbursement

Providers will be reimbursed at the lesser of their billed amount and the [maximum allowable fee](#) for the provided 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. [DHS 101.03\(35\)](#) and [107](#), Wis. Admin. Code, contain more information about covered services.

Topic #85

Emergencies

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

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

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

- PA (prior authorization) or other program requirements may be waived in emergency situations.
- [Non-U.S. citizens](#) may be eligible for covered services in emergency situations.

Topic #9657

Emergency Room Covered and Noncovered Services Under the Basic Plan

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

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

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

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

Topic #503

Immunizations

Providers are required to indicate the procedure code of the actual vaccine administered, not the administration code, on claims for all immunizations. Reimbursement for both the vaccine, when appropriate, and the administration are included in the reimbursement for the vaccine procedure code, so providers should not separately bill the administration code. Providers are required to indicate their usual and customary charge for the service with the procedure code.

The immunizations identified by CPT (Current Procedural Terminology) subsections "Immune Globulins" (procedure codes 90281-90399) and "Vaccines, Toxoids" (procedure codes 90476-90749) are covered.

Immune globulin procedure codes and the unlisted vaccine/toxoid procedure code are manually priced by ForwardHealth's pharmacy consultant. To be reimbursed for these codes, physicians are required to attach the following information to a paper claim:

- Name of drug.
- NDC (National Drug Code).
- Dosage.
- Quantity (e.g., vials, milliliters, milligrams).

Medicaid reimbursement for immune globulins, vaccines, toxoid immunizations, and the unlisted vaccine/toxoid procedure codes *includes* reimbursement for the administration component of the immunization, contrary to CPT's description of the procedure codes. Procedure codes for administration are *not* separately reimbursable.

Vaccines for Children 18 Years of Age or Younger

Most vaccines provided to members 18 years of age or younger are available through the federal VFC (Vaccines for Children) Program at no cost to the provider. If a vaccine is available through the VFC Program, providers are required to use vaccines from VFC supply for members 18 years of age or younger. ForwardHealth reimburses only the administration fee for vaccines supplied by the VFC Program.

For vaccines that are not supplied by the VFC Program, providers may use a vaccine from a private stock. In these cases, ForwardHealth reimburses for the vaccine and the administration fee.

The [Wisconsin Immunization Program](#) has more information about the VFC program. Providers may also call the VFC program at (608) 267-5148 if Internet access is not available.

Vaccines that are commonly combined, such as MMR or DTaP, are not separately reimbursable unless the medical necessity for separate administration of the vaccine is documented in the member's medical record.

If a patient encounter occurs in addition to the administration of the injection, physicians may receive reimbursement for the appropriate E&M (evaluation and management) procedure code that reflects the level of service provided at the time of the vaccination. If an immunization is the only service provided, the lowest level E&M office or other outpatient service procedure code may be reimbursed, in addition to the appropriate vaccine procedure code(s).

Vaccines for Members 19 Years of Age or Older

For vaccines from a provider's private stock that are administered to members 19 years of age or older, ForwardHealth reimburses for the vaccine and the administration fee.

Cervarix[®] Coverage

Cervarix[®] is a covered service for female members ages 9 to 26 years of age. Cervarix is available through the VFC program; therefore, providers should submit claims with HCPCS (Healthcare Common Procedure Coding System) procedure code 90650 (Human Papilloma virus [HPV] vaccine, types 16, 18 bivalent, 3 dose schedule, for intramuscular use) to be reimbursed for the

administration of the vaccine for members age 9 to 18 years of age.

Gardasil® Coverage

Gardasil® is covered for both male and female members. Gardasil is age restricted for members ages 9-26 years of age. Providers should submit claims for Gardasil® with the HCPCS procedure code 90649 (Human Papilloma virus [HPV] vaccine, types 6, 11, 16, 18 quadrivalent, 3 dose schedule, for intramuscular use) to be reimbursed for the cost of the vaccine from the providers' private stock and the administration of the vaccine for members ages 19 through 26 years. Providers should bill 90649 to be reimbursed the administration fee for members ages 9 through 18 years, as Gardasil® is available through the VFC program.

Topic #12577

Makena Injections

Makena injections are covered for BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, and Medicaid members, and are reimbursed fee-for-service for all members, including members enrolled in a state contracted HMO (health maintenance organization).

Makena is a provider-administered drug and must be injected by a medical professional. Members may not self-administer Makena injections.

Attestation to Administer Makena Injections

Makena injections may be covered if all of the following occur:

- Prescribers complete the [Attestation to Administer Makena Injections \(F-00508 \(11/11\)\)](#) before beginning treatment. If a member has begun treatment with Makena before November 15, 2011, the prescriber should complete the Attestation to Administer Makena Injections before the first Makena injection after November 15, 2011. Prescribers will only be reimbursed for Makena injections administered on and after November 15, 2011.
- Prescribers complete a [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#) and indicate process type 117.
- Prescribers submit the Attestation to Administer Makena Injections with the PA/RF to ForwardHealth by fax at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

- Prescribers receive an approved decision notice from ForwardHealth.

The Attestation to Administer Makena Injections is valid for up to a 21 week course of therapy.

Clinical Criteria

The following are clinical criteria for coverage of Makena injections. All the following criteria must be met:

- The member has experienced difficulty with prior use of 17P compound injection or the member has a medical reason that prevents the use of 17P compound injection.
- The member must be pregnant with a singleton pregnancy.

- The member must have had a previous pre-term delivery (i.e., spontaneous birth before 37 weeks gestation).
- The Makena injection treatment must be initiated between week 16 to week 20 of gestation and continue through 37 weeks gestation or delivery, whichever is first.
- The member must have a diagnosis of V23.41 (Pregnancy with history of preterm labor).

Claim Submission

Procedure code J1725 (Injection, hydroxyprogesterone caproate, 1mg), modifier U1, and the NDC (National Drug Code) for Makena injection must be indicated on professional claims for Makena injections. The addition of the U1 modifier identifies the brand Makena injection and will ensure the provider receives a brand reimbursement rate.

One dose of Makena equals 250 mg. Therefore, providers should enter "250" as the quantity. Providers are required to indicate the appropriate unit(s) on each claim submission. Claims for Makena injection may only be submitted if the drug has been administered.

Makena injection is a diagnosis-restricted drug. Diagnosis code V23.41 is the only allowable diagnosis. Claims submitted with other diagnosis other than the allowable diagnosis indicated will be denied.

Reimbursement

The maximum allowable reimbursement rate for Makena injection is \$687.50 per 250 mg injection.

Providers may be reimbursed for the administration of Makena injection by indicating procedure code 96372 on the claim.

The rate for administering Makena injection is \$3.31.

Topic #84

Medical Necessity

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

Topic #86

Member Payment for Covered Services

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

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

Topic #5677

Not Otherwise Classified Procedure Codes

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

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

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

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

Topic #66

Program Requirements

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

Topic #5697

Provider-Administered Drugs

A provider-administered drug is either an oral, injectible, intravenous, or inhaled drug administered by a physician or a designee of the physician (e.g., nurse, nurse practitioner, physician assistant). This includes, but is not limited to, all "J" codes and drug-related "Q" codes.

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

For members enrolled in BadgerCare Plus HMOs (health maintenance organizations), Medicaid SSI (Supplemental Security Income) HMOs, and most special managed care programs, BadgerCare Plus and Medicaid fee-for-service, not the member's MCO (managed care organization), reimburse providers for the following if the service is covered by BadgerCare Plus and Medicaid:

- All "J" codes.
- Drug-related "Q" codes.
- A limited number of related [administration codes](#).

For members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, claims for

these services should be submitted to BadgerCare Plus and Medicaid fee-for-service.

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

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

Obtaining Provider-Administered Drugs

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

Topic #7897

Resetting Service Limitations

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

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

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

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

Resetting service limitations does not change a member's [Benchmark Plan](#) enrollment year or a member's [Core Plan](#) enrollment year.

Topic #824

Services That Do Not Meet Program Requirements

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

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

- Services for which records or other documentation were not prepared or maintained.
- Services for which the provider fails to meet any or all of the requirements of [DHS 106.03](#), Wis. Admin. Code, including, but not limited to, the requirements regarding timely submission of claims.
- Services that fail to comply with requirements or state and federal statutes, rules, and regulations.
- Services that the DHS (Department of Health Services), the PRO (Peer Review Organization) review process, or BadgerCare Plus determines to be inappropriate, in excess of accepted standards of reasonableness or less costly

alternative services, or of excessive frequency or duration.

- Services provided by a provider who fails or refuses to meet and maintain any of the enrollment requirements under [DHS 105](#), Wis. Admin. Code.
- Services provided by a provider who fails or refuses to provide access to records.
- Services provided inconsistent with an intermediate sanction or sanctions imposed by the DHS.

Topic #510

Telemedicine

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

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

Reimbursable Telemedicine Services

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

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

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

- Office or other outpatient services (CPT (Current Procedural Terminology) procedure codes 99201-99205, 99211-99215).
- Office or other outpatient consultations (CPT codes 99241-99245).
- Initial inpatient consultations (CPT codes 99251-99255).
- Outpatient mental health services (CPT codes 90785, 90791-90792, 90832-90834, 90836-90840, 90845-90847, 90849, 90875, 90876, and 90887).
- Health and behavior assessment/intervention (CPT codes 96150-96152, 96154-96155).
- ESRD (end-stage renal disease)-related services (CPT codes 90951-90952, 90954-90958, 90960-90961).
- Outpatient substance abuse services (HCPCS (Healthcare Common Procedure Coding System) codes H0022, H0047, T1006).

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

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

whether they are performed face-to-face or through telemedicine.

Only one eligible provider may be reimbursed per member per DOS (dates of service) for a service provided through telemedicine unless it is medically necessary for the participation of more than one provider. Justification for the participation of the additional provider must be included in the member's medical record.

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

Services Provided by Ancillary Providers

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

Federally Qualified Health Centers and Rural Health Clinics

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

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

Members Located in Nursing Homes

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

Out-of-State Providers

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

Documentation Requirements

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

Eligible Members

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

Telemedicine and Enhanced Reimbursement

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

qualify for pediatric or HPSA-enhanced reimbursement with both modifier "GT" and the applicable pediatric or HPSA modifier.

Originating Site Facility Fee

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

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

Claim Submission

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

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

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

Outpatient Hospital Reimbursement

Wisconsin Medicaid will reimburse outpatient hospitals only the facility fee (Q3014) for the service. Wisconsin Medicaid will separately reimburse an outpatient hospital for other covered outpatient hospital services only if they are provided beyond those included in the telemedicine service on the same DOS. Professional services provided in the outpatient hospital are separately reimbursable.

Store and Forward Services

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

Health Professional Shortage Areas

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

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

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

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

Topic #12717

Wearable Cardioverter Defibrillator

Rental of a WCD (wearable cardioverter defibrillator) is a covered service with [PA \(prior authorization\)](#). The WCD is indicated for adult members at high risk for sudden cardiac death and is used on an outpatient basis. This equipment is intended for short-term use under medical supervision. The WCD is designed to perform the same functions as an automatic ICD (implantable cardioverter defibrillator), but is worn outside the body and is therefore noninvasive.

Reimbursement Policy and Claims

Delivery, setup and training are included in the charges for rental equipment. Separate payment for cables, alarms, electrodes, belts, holsters, lead wires, battery packs, battery charger, monitor, the garment and other supplies will not be made as these items are included in the charges for rental equipment as well.

Equipment rental is covered only as long as medical necessity exists. Once an ICD is implanted or a heart transplant takes place, the WCD is no longer needed. Providers may not bill for dates of service when medical necessity no longer exists.

Evaluation and Management

Topic #481

A Comprehensive Overview

E&M (evaluation and management) services include office visits, hospital visits, and consultations. Specific services include examinations, evaluations, treatments, preventive pediatric and adult health supervision, and similar medical services.

BadgerCare Plus covers most of the categories of E&M services described in CPT (Current Procedural Terminology).

BadgerCare Plus does *not* cover E&M services in the following CPT categories:

- Prolonged Physician Services Without Direct Patient Contact.
- Case Management Services.
- Care Plan Oversight Services.
- Counseling and/or Risk Factor Reduction Intervention.
- Special E&M Services.

BadgerCare Plus does not cover services provided in group settings or telephone conversations between the provider and the member, except for [outpatient mental health](#) and [substance abuse services](#). E&M services must be provided to members on a one-on-one basis.

Topic #482

Concurrent Care

BadgerCare Plus covers E&M (evaluation and management) services provided on the same DOS (date of service) by two or more physicians to a member during an inpatient hospital or nursing home stay only when medical necessity is documented in the member's medical record.

Topic #483

Consultations

Inpatient and outpatient office consultations (CPT (Current Procedural Terminology) procedure codes 99241-99255) are covered when provided to a member at the request of another provider and when medically necessary and appropriate. If an additional request for an opinion or advice regarding the same or a new problem for the same member is received from a second provider and documented in the medical record, the consultation procedure codes may be used again by the consulting provider. Any qualified provider may request a consultation.

If the consulting provider assumes responsibility for management of a portion or all of the member's medical condition, the use of consultation procedure codes is no longer appropriate by that provider. The provider should then use the appropriate level E&M (evaluation and management) code for the POS (place of service).

For a "consultation" initiated by the member or member's family (e.g., a request for a second surgical opinion) and not requested by a provider, the "consulting" provider should use the appropriate level E&M code, rather than consultation procedure codes.

Covered Consultations

An E&M consultation requires face-to-face contact between the consultant and the member, either in person or via telemedicine, where appropriate. A consultation must always result in a written report that becomes a part of the member's permanent medical record.

Claims Submission

Claims for consultations must include the referring provider's name and NPI (National Provider Identifier).

Topic #484

Critical Care and Prolonged Services

Wisconsin Medicaid reimburses up to four hours per DOS (date of service) for critical care (CPT (Current Procedural Terminology) procedure codes 99291-99292) and prolonged services (CPT procedure codes 99354-99357 and 99360).

To request reimbursement for time in excess of four hours per DOS, providers should submit an [Adjustment/Reconsideration Request \(F-13046 \(07/12\)\)](#) for an allowed claim. Supporting clinical documentation (e.g., a history and physical exam report or a medical progress note) that identifies why reimbursement for services in excess of four hours is requested must be included.

Wisconsin Medicaid only reimburses prolonged care services (CPT procedure codes 99354-99357 and 99360) if there is face-to-face contact between the provider and the member. Prolonged care services without face-to-face contact (CPT codes 99358 and 99359) are not covered.

Ambulance Services

Critical care services provided by physicians in an air or ground ambulance are reimbursed under either critical care or prolonged care procedure codes. Claims for services provided in an ambulance must be submitted on a paper claim with a copy of the physician's clinical record attached.

Wisconsin Medicaid does not reimburse physicians for supervising from the home base of a hospital's emergency transportation unit or for supervising in the ambulance.

Topic #3414

Documentation

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

The documentation in the member's medical record for each service must justify the level of the E&M code billed. Providers may access the CMS documentation guidelines on the [CMS Web site](#). BadgerCare Plus policy information can be found in service-specific areas of the Online Handbook or on the ForwardHealth Portal.

Topic #485

Emergency Department Services

Physician services providers may receive reimbursement for an emergency E&M (evaluation and management) service (CPT (Current Procedural Terminology) codes 99281-99285) in addition to any surgical procedures or consultations performed by the same rendering provider for the same member on the same DOS (date of service). Providers are required to maintain supporting documentation in their files that justifies the level of the emergency E&M procedure submitted on the claim, as well as the surgical procedure and/or consultation.

Topic #486

Evaluation and Management Services Provided with Surgical Procedures

If a provider performs an office or a hospital visit and a surgical procedure on the same DOS (date of service) for the same member, the provider will receive reimbursement for the surgical procedure only. However, if the surgery is a minor surgery (as determined by Wisconsin Medicaid), the provider may submit an [Adjustment/Reconsideration Request \(F-13046 \(07/12\)\)](#) form for the allowed surgery claim to request additional reimbursement for the E&M (evaluation and management) service.

If the E&M service was unrelated to the surgery, the E&M service may be reimbursed if it is billed under a different diagnosis code than the diagnosis code for the surgery.

Topic #487

Family Planning Services

Family planning services are defined as services performed to enable individuals of childbearing age to determine the number and spacing of their children. This includes minors who are sexually active. To enable the state to obtain Federal Financial Participation funding for family planning services, the accurate completion of the following elements on the claim is essential:

- An ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis code from the [V25 range](#) or [modifier "FP"](#) if the service provided was related to family planning and a diagnosis code in the V25 range is not appropriate.
- An appropriate diagnosis code reference to the procedure code.
- The Family Planning Indicator set to "Y."

Topic #488

Hospital Services

Wisconsin Medicaid ordinarily reimburses physicians for a moderate-level hospital admission procedure code if the physician has provided an E&M (evaluation and management) service or consultation at the highest level of service in the seven days prior to the hospital admission date.

Topic #489

Nursing Home Visits

Wisconsin Medicaid reimburses one routine nursing home visit per calendar month per member. If a physician visits a nursing home member more frequently, medical records must document the medical necessity of the additional visits.

When submitting a claim for a nursing home visit, use the most appropriate CPT (Current Procedural Terminology) procedure code based on the level of service provided.

Topic #490

Observation Care

Observation care is covered. Observation care includes all E&M (evaluation and management) services performed by the admitting physician on the date a member is admitted into observation care. This includes related services provided at other sites and all E&M services provided in conjunction with the admission into observation status.

Only the admitting physician may submit a claim for observation care. Other physicians are required to use another appropriate E&M outpatient or consultation procedure code.

When submitting claims for observation care, use the appropriate CPT (Current Procedural Terminology) procedure code. Providers may refer to the [maximum allowable fee schedules](#) for the most current observation care procedure codes. Only one observation care procedure code may be reimbursed per member, per DOS (date of service), per provider. Observation care codes are not reimbursed for members admitted into hospital inpatient care on the same DOS. Only POS (place of service) codes "22" (outpatient hospital) and "23" (emergency room - hospital) may be indicated on claims for observation care.

Topic #491

Office and Other Outpatient Visits

Established Patient

An established patient is one who has, within the past three years, received professional services from the same physician or another physician of the same specialty who belongs to the same group practice.

New Patient

A new patient is defined as a patient who is new to the provider and whose medical and administrative records need to be established. A new patient has not received professional services from either the physician or group practice within the past three years.

Office Visit Daily Limit

Wisconsin Medicaid reimburses only one office visit per member, per provider, per DOS (date of service). However, a problem-focused office visit may be reimbursed in addition to a preventive medicine visit by the same provider on the same DOS if an abnormality is encountered or a pre-existing problem is addressed in the process of performing the preventive medicine visit. The abnormality/problem must be a significant, medically necessary, separately identifiable E&M (evaluation and management) service that is documented in the member's medical record. In addition, the abnormality/problem must be significant enough to require additional work to perform the key component of a problem-oriented E&M service.

Separate reimbursement for more than one E&M visit on the same DOS as a preventive visit are subject to post-pay review and may be recouped if documentation is inadequate to justify separate payment.

Office Located in Hospital

Physicians may submit claims for services performed in a physician's office that is located in an outpatient hospital facility with POS (place of service) code "11" (office).

Office Visits and Counseling

A physician or a physician's designee may be reimbursed for counseling (including counseling a member for available courses of treatment) using E&M office visit procedure codes 99201-99215, even if counseling was the only service provided during the visit. Counseling may include the discussion of treatment options that are not covered (e.g., experimental services). Counseling procedure codes 99401-99404 are non-reimbursable as physician services.

Topic #492

Preventive Medicine Services

Preventive medicine services are those office visits that relate to preventive medicine E&M (evaluation and management) of infants, children, adolescents, and adults. Preventive medicine services include the following:

- Counseling.
- Anticipatory guidance.
- Risk factor reduction interventions.

Annual Physicals

Wisconsin Medicaid reimburses a maximum of one comprehensive, routine physical examination per calendar year per member. Members may use this examination to fulfill employment, school entrance, or sports participation requirements.

Note: Wisconsin Medicaid considers preventive medicine visits for members under age 21 as HealthCheck visits.

HealthCheck Screenings

[HealthCheck](#) is Wisconsin Medicaid's federally mandated program known nationally as EPSDT (Early and Periodic Screening, Diagnosis, and Treatment). HealthCheck services consist of a comprehensive health screening of Medicaid members under 21 years of age that includes *all* the following:

- A comprehensive health and developmental history (including anticipatory guidance).
- A comprehensive unclothed physical exam.
- An age-appropriate vision screen.
- An age-appropriate hearing screen.
- An oral assessment plus referral to a dentist beginning at age 3.
- Appropriate immunizations.
- Appropriate laboratory tests (i.e., [blood lead testing](#)).

Preventive medicine procedure codes 99381-99385 or 99391-99395 should only be used by providers when submitting claims for comprehensive HealthCheck screens. Other preventive visits should be billed using the appropriate office visit code. Providers should also indicate modifier "UA" with the appropriate procedure code if a comprehensive screen results in a referral for further evaluation and treatment. If a comprehensive HealthCheck screen does *not* result in a referral for further evaluation or treatment, providers should *only* indicate the appropriate procedure code, not the modifier.

Interperiodic Visits

Medically necessary interperiodic screening exams to follow up on detected problems or conditions are covered. Examples of interperiodic screenings include the following:

- Immunizations.
- Retesting for an elevated blood lead level.
- Retesting for a low hematocrit.

Providers should submit claims for interperiodic visits using the appropriate office visit procedure code (99201-99205, 99211-99215) along with a preventive medicine diagnosis code.

HealthCheck "Other Services"

On occasion, a HealthCheck screening may identify the need for health care services that are not otherwise covered or that exceed Medicaid limitations. These services are called [HealthCheck "Other Services"](#). Federal law requires that these services be reimbursed by Wisconsin Medicaid through HealthCheck "Other Services" if they are medically necessary and prior authorized. The purpose of HealthCheck "Other Services" is to assure that medically necessary services are available to members under 21 years of age.

Topic #3451

Primary Care Treatment and Follow-up Care for Mental Health and Substance Abuse

Initial primary care treatment and follow-up care are covered for members with mental health and/or substance abuse needs provided by primary care physicians, physician assistants, and nurse practitioners. Wisconsin Medicaid will reimburse the previously listed providers for CPT (Current Procedural Terminology) E&M (evaluation and management) services (procedure codes 99201-99205 and 99211-99215) with an ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis code applicable for mental health and/or substance abuse services. As a reminder, these services may be eligible for [HPSAs \(Health Professional Shortage Areas\)](#) and pediatric enhanced reimbursements.

Refer to the latest edition of CPT or to the CMS (Centers for Medicare and Medicaid Services) 1995 or 1997 Documentation Guidelines for Evaluation and Management Services via the [CMS Web site](#) for guidelines for determining the appropriate level of E&M services.

Since counseling may constitute a significant portion of the E&M services delivered to a member with mental health and/or substance abuse diagnoses, providers are required to fully document the percentage of the E&M time that involved counseling. This documentation is necessary to justify the level of E&M visit.

Claims for services delivered by ancillary staff under the direct, on-site supervision of a primary care physician must be submitted under the NPI (National Provider Identifier) of the supervising physician. Coverage and reimbursement are limited to CPT code 99211 or 99212 as appropriate.

Topic #494

Tobacco Cessation Drugs and Services

Tobacco cessation services are reimbursed as part of an E&M (evaluation and management) office visit provided by a physician, physician assistant, nurse practitioner, and ancillary staff. Services must be one-on-one, face-to-face between the provider and the

member. BadgerCare Plus does not cover group sessions or telephone conversations between the provider and member under the E&M procedure codes.

Tobacco cessation services covered under BadgerCare Plus and Wisconsin Medicaid include outpatient substance abuse services or outpatient mental health services, as appropriate.

Tobacco cessation services covered under the BadgerCare Plus Core Plan include medically necessary E&M visits, as appropriate.

Ancillary staff can provide tobacco cessation services only when under the direct, on-site supervision of a Medicaid-enrolled physician. When ancillary staff provide tobacco cessation services, BadgerCare Plus reimburses up to a level-two office visit (CPT (Current Procedural Terminology) code 99212). The supervising provider is required to be listed as the rendering provider on the claim.

Drugs for Tobacco Cessation

The BadgerCare Plus Standard Plan and Medicaid cover legend drugs for tobacco cessation.

The BadgerCare Plus Benchmark Plan and the Core Plan cover generic legend drugs for tobacco cessation.

Nicotine gum or patches available over the counter are covered by the Standard Plan, the Benchmark Plan, the Core Plan, and Medicaid.

Certain Standard Plan and Benchmark Plan members may be eligible to participate in Striving to Quit [Wisconsin Tobacco Quit Line](#) or [First Breath](#) initiatives.

A written prescription from a prescriber is required for both federal legend *and* OTC (over-the-counter) tobacco cessation products. Prescribers are required to indicate the appropriate diagnosis on the prescription. PA (prior authorization) is required for uses outside the approved diagnosis (ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis code 305.1).

HealthCheck "Other Services"

Topic #22

Definition of HealthCheck "Other Services"

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

Topic #1

Prior Authorization

To receive PA (prior authorization) for HealthCheck "Other Services," providers are required to [submit a PA request via the ForwardHealth Portal](#) or to submit the following via [fax](#) or [mail](#):

- A completed [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#) (or [PA/DRF \(Prior Authorization/Dental Request Form, F-11035 \(07/12\)\)](#), or [PA/HIAS1 \(Prior Authorization Request for Hearing Instrument and Audiological Services 1, F-11020 \(05/13\)\)](#)).
 - The provider should mark the checkbox titled "HealthCheck Other Services" at the top of the form.
 - The provider may omit the procedure code if he or she is uncertain what it is. The ForwardHealth consultant will assign one for approved services.
- The appropriate service-specific PA attachment.
- Verification that a comprehensive HealthCheck screening has been provided within 365 days prior to ForwardHealth's receipt of the PA request. The date and provider of the screening must be indicated.
- Necessary supporting documentation.

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

Topic #41

Requirements

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

- The condition being treated is identified in a HealthCheck screening that occurred within 365 days of the PA (prior authorization) request for the service.
- The service is provided to a member who is under 21 years of age.
- The service may be covered under federal Medicaid law.
- The service is medically necessary and reasonable.
- The service is prior authorized before it is provided.

- Services currently covered are not considered acceptable to treat the identified condition.

ForwardHealth has the authority to do all of the following:

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

Medicine Services

Topic #493

Allergy Tests

Claims for allergy tests must include the appropriate CPT (Current Procedural Terminology) procedure code(s) and the quantities of items provided or tests performed.

Topic #495

Audiometry

Basic comprehensive audiometry includes all of the following:

- Pure tone air audiometry.
- Pure tone bone audiometry.
- Speech audiometry, threshold.
- Speech audiometry, discrimination.

If a claim is submitted for basic comprehensive audiometry testing in combination with any of the individual components of the comprehensive test for the same member on the same DOS (date of service), only the comprehensive audiometry testing is reimbursed.

A physician referring a member to a hearing instrument specialist for a hearing aid must complete a [PA/POR \(Prior Authorization/Physician Otological Report, F-11019 \(07/12\)\)](#). The physician should give page one (or a copy) of the PA/POR to the member and keep page two (or a copy of it) in the member's medical records.

Topic #496

Biofeedback

Wisconsin Medicaid reimburses physicians and physician assistants for biofeedback training, procedure codes 90901 and 90911. Only psychiatrists may be reimbursed for individual psychophysiological therapy incorporating biofeedback, procedure codes 90875 and 90876. Other service areas of this Web site contain more information about mental health and substance abuse services.

Topic #498

Central Nervous System Assessments and Tests

Providers may submit claims with up to six units of any combination of central nervous system assessments and tests for one DOS (date of service). Computer-based testing of student athletes for post-concussion syndrome is excluded from this limit.

Computer-Based Testing of Student Athletes for Post-Concussion Syndrome

Wisconsin Medicaid reimburses physicians, physician assistants, and nurse practitioners for computer-based neuropsychological post-concussion testing of student athletes. The rendering provider must be trained to correctly interpret the test.

The computer-based neuropsychological post-concussion test should be compared with a computer-based pre-concussion baseline test administered by the student's athletic organization before the injury occurred. The administration of a pre-concussion baseline test is not reimbursable.

On claims for computer-based neuropsychological post-concussion testing of student athletes, providers should indicate CPT (Current Procedural Terminology) procedure code 96120 (Neuropsychological testing [eg, Wisconsin Card Sorting Test], administered by a computer, with qualified health care professional interpretation and report). The allowable ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis codes for computer-based neuropsychological post-concussion testing of student athletes are 310.2 (Postconcussion syndrome) or 850.0-850.9 (Concussion).

Topic #502

Certificate of Need Requirements for Members Admitted to an Institution for Mental Disease

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

The CON assessments must be completed by a team of professionals, including at least one physician, working in cooperation with the hospital. One of the following completed forms must be readily available for ERO (external review organization) or DHS (Department of Health Services) review:

- [Certification of Need for Elective/Urgent Psychiatric/Substance Abuse Admissions to Hospital Institutions for Mental Disease for Members Under Age 21 \(F-11047 \(02/09\)\)](#).
- [Certification of Need for Emergency Psychiatric/Substance Abuse Admissions to Hospital Institutions for Mental Disease for Members Under Age 21 and in Case of Medicaid Determination After Admission \(F-11048 \(02/09\)\)](#).

Topic #497

Chemotherapy

When chemotherapy for a malignant disease is provided in a physician's office, separate reimbursement is allowed for the following:

- E&M (evaluation and management) visits.
- The drug, including injection of the drug.
- Therapeutic infusions.
- Supplies.
- Physician-administered oral anti-emetic drugs.

Use procedure code 99070 for supplies and materials provided by the physician.

Chemotherapy drugs (HCPCS (Healthcare Common Procedure Coding System) codes J9000-J9999) are covered. Reimbursement for these procedure codes includes the cost of the drug and the charge for administering the drug. (If the physician's office does not supply the drug, use procedure code 90782 or 90784 on claims for the injection. Use the appropriate

procedure code for the infusion when performed by the physician.)

When chemotherapy for a malignancy is provided in an inpatient hospital, outpatient hospital, or nursing home setting, physician services providers may receive reimbursement for the E&M visit only.

Anti-Emetic Drugs

Physician-administered anti-emetic drugs for members receiving chemotherapy are covered. The appropriate HCPCS "Q" code should be indicated when submitting a claim for a physician-administered oral anti-emetic drug for a Medicaid member receiving chemotherapy. Before submitting a claim, providers are responsible for verifying that a pharmacy is not already billing for an anti-emetic drug given to a member for the same DOS (date of service).

Topic #499

End-Stage Renal Disease Services

Physician services providers should submit claims with CPT (Current Procedural Terminology) procedure codes 90951-90970 for professional ESRD (end-stage renal disease)-related services. These services may be reimbursed once per calendar month per member. Member copayments are deducted for these services as appropriate.

Dialysis Treatment Provided Outside the Member's Home

Providers should submit claims with procedure codes 90951-90962 for ESRD members who are receiving dialysis treatment somewhere other than in their home. Providers should indicate the appropriate procedure code based on the age of the member and the number of face-to-face visits per month. The visits may occur in the physician's office, an outpatient hospital or other outpatient setting, or the member's home, as well as the dialysis facility. If the visits occur in multiple locations, providers should indicate on claims the POS (place of service) code where most of the visits occurred.

If an ESRD member is hospitalized during the month, the physician may submit a claim with the code that reflects the appropriate number of face-to-face visits that occurred during the month on days when the member was not in the hospital.

Indicate the first DOS of the month and always indicate a quantity of "1.0" to represent a month of care. Do not report the specific dates of each dialysis session on the claim.

Home Dialysis Members

Providers should submit claims with procedure codes 90963-90966 for home dialysis ESRD members. The procedure codes differ according to age, but do not specify the frequency of required visits per month.

When submitting claims for these procedure codes, report the first DOS of the month and always indicate a quantity of "1.0" to represent a month of care. Do not report the specific dates of each dialysis session.

Home Dialysis Members Who Are Hospitalized

Procedure codes 90967-90970 are for home dialysis ESRD members who are hospitalized during the month.

These procedure codes can be used to report daily management for the days the member is not in the hospital. For example, if a home dialysis member is in the hospital for 10 days and is cared for at home the other 20 days during the month, then 20 units of one of the codes would be used. If a home dialysis member receives dialysis in a dialysis center or other facility during the month, the physician is still reimbursed for the management fee and may not be reimbursed for procedure codes 90951-90962.

Paper Claims

When submitting claims for procedure codes 90967-90970, report the DOS for ESRD-related care within a calendar month, with the first DOS as the "From DOS" and the last DOS as the "To DOS." Indicate the actual number of days under the physician's care within the calendar month as the quantity.

Electronic Billing

Providers submitting 837P (837 Health Care Claim: Professional) transactions should indicate individual DOS per detail line. Providers may indicate a range of dates per detail line using the 837P transaction only when the service is performed on consecutive days.

Topic #500

Evoked Potentials

Only audiologists and physicians with specialties of neurology, otolaryngology, ophthalmology, physical medicine and rehabilitation, anesthesiology, and psychiatry can be reimbursed for evoked potential testing.

The following evoked potential tests are covered:

- Brain stem evoked response recording.
- Visual evoked potential study.
- Somatosensory testing.
- Intraoperative neurophysiological testing reimbursed by the hour.

These evoked potential tests are allowed once per day per member. When two or more types of evoked potential tests are performed on the same DOS (date of service) (e.g., brain stem and visual), reimbursement is 100 percent of the Medicaid maximum allowable fee for the first test, with a lesser amount for the second and subsequent tests.

Topic #501

Fluoride — Topical Applications

Information is available for [DOS \(dates of service\) before January 1, 2013](#).

Topical application of fluoride to a child's teeth is a safe and effective way to prevent tooth decay as part of a comprehensive oral health program.

Coverage

Wisconsin Medicaid recommends that children under age 5 who have erupted teeth receive topical fluoride treatment. Children at low or moderate risk of early childhood caries should receive one or two applications per year; children at higher risk should receive three or four applications per year.

The most accepted mode of fluoride delivery in children under age 5 is a fluoride varnish. OTC (over-the-counter) mouth rinses are not covered.

Submitting Claims

When submitting claims for topical fluoride treatment, indicate procedure code D1206 (Topical fluoride varnish; therapeutic application for moderate to high caries risk patients) or D1208 (Topical application of fluoride). Providers may also submit claims with HealthCheck and office visit HCPCS procedure codes for these services.

In cases where more than two fluoride treatments per year are medically necessary, providers are required to retain supporting clinical documentation in the member's file indicating the need for additional treatments.

[Ancillary staff](#) (e.g., physician assistants, nurse practitioners) are required to follow certain billing procedures.

Wisconsin Medicaid will separately reimburse providers for the appropriate level office visit or preventive visit at which the fluoride application was performed.

Training Materials

An [Oral Health Provider Training guide](#) describing how providers may perform lift-the-lip oral screenings, apply fluoride varnish to a small child's teeth, and provide basic oral health guidance to parents is available.

Topic #504

Laboratory Test Preparation and Handling Fees

If a physician obtains a specimen and forwards it to an outside laboratory, only the outside laboratory that performs the procedure may be reimbursed for the procedure. The physician who forwards the specimen is only reimbursed a handling fee.

When forwarding a specimen from a physician's office to an outside laboratory, submit claims for preparation and handling fees using procedure code 99000. When forwarding a specimen from someplace other than a physician's office to a laboratory, submit claims using procedure code 99001. It is not necessary to indicate the specific laboratory test performed on the claim.

A handling fee is not separately reimbursable if the physician is reimbursed for the professional and/or technical component of the laboratory test.

Additional Limitations

The following are additional limitations on reimbursement for lab handling fees:

- One lab handling fee is reimbursed per provider, per member, per outside laboratory, per DOS (date of service), regardless of the number of specimens sent to the laboratory.
- More than one handling fee is reimbursed when specimens are sent to two or more laboratories for one member on the same DOS. Indicate the number of laboratories and the total charges on the claim. The name of the laboratory does not need to be indicated on the claim; however, this information must be documented in the provider's records.
- The DOS must be the date the specimen is obtained from the member.

Topic #505

Mental Health Services

Except for biofeedback and pharmacological management, Mental Health Services are reimbursable only for Medicaid-enrolled physicians with a psychiatric specialty.

Topic #506

Provider-Administered Drugs

Procedure codes for Medicaid-covered [provider-administered drugs](#) are listed in the [physician services maximum allowable fee schedule](#). Providers should use the appropriate fee schedule in conjunction with the most recent HCPCS (Healthcare Common Procedure Coding System) coding book for descriptions.

Diagnosis Restrictions

Diagnosis restrictions that apply to NDCs (National Drug Codes) also apply to corresponding HCPCS codes when billed as provider-administered drugs. Wisconsin Medicaid requires a valid and acceptable ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis code on claims for selected provider-administered drugs. Diagnosis code restrictions are based on FDA (Food and Drug Administration)-approved indications and compendium standards.

Medicaid has identified a [list](#) of diagnosis-restricted provider-administered drugs and the respective HCPCS codes, allowable diagnosis codes, and disease descriptions. The list may be updated periodically.

If the member's diagnosis is not one of the allowable diagnoses for the code, providers are required to obtain PA (prior authorization).

Prior Authorization Requirements

Physician services providers are required to obtain PA for [certain Medicaid-allowable drugs](#) and provider-administered drugs that are *not* provided with an allowable diagnosis code. Providers are required to use the [PA/JCA \(Prior Authorization/"J" Code Attachment, F-11034 \(07/12\)\)](#) along with the [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#) to request PA.

Providers are required to include with the PA request peer-reviewed medical literature from scientific medical or pharmaceutical publications in which original manuscripts are rejected or published only after having been reviewed by unbiased independent experts. Only the diagnosis codes included in the diagnosis code-restricted physician-administered drugs list are reimbursable without PA.

Unclassified Drugs

Providers should *not* submit claims with HCPCS procedure code J3490 when there is another procedure code that better describes the drug. Claims with J3490 will be denied if there is a more specific code that may be used.

Procedure code J3490 requires PA *only* when the drug may also be used as a fertility drug.

To be reimbursed for an unclassified drug that does not require PA or a HCPCS code that does not have a maximum allowable fee listed in the fee schedule for physicians, providers are required to submit a paper 1500 Health Insurance Claim Form and attach the following information:

- Name of drug.
- NDC.
- Dosage.
- Quantity (e.g., vials, milliliters, milligrams).

Reimbursement

Wisconsin Medicaid separately reimburses providers for the administration component of provider-administered drugs, except for any vaccine or immune globulin. Administration is included in the reimbursement for vaccines and immune globulins in the CPT

code range 90281-90799. Only one administration procedure code may be reimbursed for the same provider for the same member on the same DOS (date of service) for the same provider-administered drug, unless otherwise noted in the procedure code description.

Topic #507

Psychiatric Medication Checks

Providers who are not enrolled as mental health providers and who perform medication checks for psychiatric patients are required to use HCPCS (Healthcare Common Procedure Coding System) procedure code M0064 (Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders).

Psychiatrists and APNPs (Advanced Practice Nurse Prescribers) with a psychiatric specialty enrolled as mental health providers are required to report the appropriate E&M (evaluation and management) code for medication checks on psychiatric patients.

Claims submitted with the incorrect procedure code and provider type combination will be denied.

Topic #508

Screenings

Medicaid-allowable screening procedure codes are identified in the [allowable procedure codes list for physician services providers](#). The following are general principles for coverage of screening and diagnostic procedures:

- Wisconsin Medicaid reimburses both screening and diagnostic tests and procedures under the appropriate procedure codes.
- Reimbursement for office visits is included with the reimbursement for surgical procedures, whether diagnostic or screening (e.g., colonoscopy, flexible sigmoidoscopy). Providers should not submit claims for office visits when performing surgical procedures on the same DOS (date of service).
- Laboratory and radiology screening and diagnostic procedures are separately reimbursable when submitted with an office visit procedure code on the same DOS.

Screening Procedures Coverage

Providers should indicate screening procedure codes when submitting claims in the following instances:

- For routine tests or procedures performed to identify members at increased risk for diseases.
- When a member is asymptomatic or does not have a personal history of the disease (or related conditions) for which the screening test is being performed.

Wisconsin Medicaid does not limit the frequency, age criteria, or reasons for screening; rather, this is left to best medical judgment based on standard medical practice and the patient's individual circumstances.

Claims for screenings must have the diagnosis code field completed (e.g., a preventive code). For example, a claim for a glaucoma screening could indicate ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis code V80.1 (Special screening for neurological, eye, and ear diseases; Glaucoma).

Diagnostic Procedures

Providers should indicate diagnostic procedure codes when submitting claims in the following instances:

- There are symptoms or other indications of a medical problem.
- To confirm a previous diagnosis.
- There is a personal history of a medical problem or related condition.
- During a screening, a problem or medical condition is found and a biopsy or other sample is taken for further study and analysis.

Service-Specific Information

The following information gives details about each kind of screening and/or when to request reimbursement for diagnostic services. Refer to CPT (Current Procedural Terminology) for diagnostic procedure codes.

Breast Cancer - Mammography

Wisconsin Medicaid does not have limitations on the frequency of mammography. Providers may be reimbursed for both a screening mammography and a diagnostic mammography for the same patient on the same DOS if they are performed as separate films. Reasons for the separate procedures must be documented in the member's medical record.

Colorectal Cancer

Providers may submit claims for a variety of colorectal cancer screening or diagnostic tests, including laboratory tests, flexible sigmoidoscopy, proctosigmoidoscopy, barium enema, and colonoscopy. Providers should indicate the HCPCS (Healthcare Common Procedure Coding System) or CPT procedure code that best reflects the nature of the procedure. If abnormalities (e.g., polyps) are found during a screening colonoscopy or sigmoidoscopy and biopsies taken or other coverage criteria are met (e.g., personal history of colon cancer), then the CPT diagnostic procedure code should be indicated.

Screening CT colonography will be covered with PA under the following circumstances:

- Once every five years for members 50 years of age or older who are unable, due to an accompanying medical condition, to undergo screening optical colonoscopy or who have failed optical colonoscopy.
- Once every five years for members younger than 50 years of age who are unable, due to an accompanying medical condition, to undergo screening optical colonoscopy or have had a failed optical colonoscopy and are at increased risk for colorectal cancer or polyps due to one of the following:
 - Strong family history of colorectal cancer or polyps in a first-degree relative younger than 60 years of age.
 - Two or more first-degree relatives of any age with a history of colorectal cancer.
 - Known family history of colorectal cancer syndromes such as familial adenomatous polyposis (FAP) or hereditary nonpolyposis colon cancer (HNPCC).

The following are accompanying medical conditions:

- An optical colonoscopy is incomplete due to an inability to pass the colonoscope because of an obstructing rectal or colon lesion, stricture, scarring from previous surgery, tortuosity, redundancy, or severe diverticulitis.
- If the member is receiving chronic anti-coagulation that cannot be interrupted.
- If the member is unable to tolerate optical colonoscopy, associated sedation, or specified bowel prep due to cardiac, pulmonary, neuromuscular, or metabolic comorbidities.

Glaucoma

Wisconsin Medicaid reimburses for glaucoma screening examinations when they are performed by or under the direct supervision of an ophthalmologist or optometrist. If a member has a previous history of glaucoma, indicate the CPT diagnostic procedure code when submitting a claim for services. In either case, Wisconsin Medicaid will not separately reimburse a provider for a glaucoma screening if an ophthalmological exam is provided to a member on the same DOS. Glaucoma screening and diagnostic examinations are included in the reimbursement for the ophthalmological exam.

Pap Smears

Wisconsin Medicaid covers both screening and diagnostic Pap smears. Providers may receive reimbursement for both a screening and diagnostic Pap smear for the same DOS if abnormalities are found during a screening procedure and a subsequent diagnostic procedure is done as a follow-up. Providers are required to document this in the member's medical record.

Pelvic and Breast Exams

Wisconsin Medicaid reimburses for a screening pelvic and breast exam if it is the only procedure performed on that DOS. A pelvic and breast exam (HCPCS procedure code G0101) performed during a routine physical examination or a problem-oriented office visit is not separately reimbursable but is included in the reimbursement for the physical examination or office visit. When using an E&M office visit procedure code, the time and resources for the pelvic and breast exam should be factored into the determination of the appropriate level for the office visit.

Prostate Cancer

The following tests and procedures provided to an individual for the early detection and monitoring of prostate cancer and related conditions are covered:

- Screening DRE (Digital Rectal Examination) — This test is a routine clinical examination of an asymptomatic individual's prostate for nodules or other abnormalities of the prostate.
- Screening PSA (Prostate Specific Antigen) Blood Test — This test detects the marker for adenocarcinoma of the prostate.
- Diagnostic PSA Blood Test — This test is used when there is a diagnosis or history of prostate cancer or other prostate conditions for which the test is a reliable indicator.

Reimbursement for a DRE is included in the reimbursement for a covered E&M (evaluation and management) or preventive medical examination when the services are furnished to a member on the same day. If the DRE is the only service provided, the applicable procedure code may be reimbursed. The screening and diagnostic PSA tests are separately reimbursable when performed on the same DOS as an E&M or preventive medical exam.

Topic #509

Substance Abuse Services

The following substance abuse services are covered:

- Individual substance abuse therapy.
- Family substance abuse therapy.
- Group substance abuse therapy.

Physicians interested in providing substance abuse services may refer to the [Outpatient Substance Abuse](#) service area or call [Provider Services](#).

Topic #9957

Synagis Coverage

Synagis[®] (palivizumab), a monoclonal antibody, is used to prevent lower respiratory tract diseases caused by RSV (respiratory syncytial virus) in premature, high-risk infants. The prevalence for RSV is from October through April and the treatment season in the northern hemisphere is generally from November through March. The general recommendation for treatment with Synagis[®]

during a treatment season is to administer the first dose in November and the last dose in March.

PA (prior authorization) is required for Synagis[®].

Synagis[®] is not part of the provider-administered drugs carve-out policy; therefore, a member's MCO (managed care organization) should reimburse providers for Synagis[®].

Claims for Synagis[®] must be submitted using the 837P (837 Health Care Claim: Professional) transaction or on the 1500 Health Insurance Claim Form. Prescribers and pharmacy providers are required to indicate CPT (Current Procedural Terminology) procedure code 90378 (Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each) and the appropriate unit(s) on each claim submission.

Providers should *not* indicate HCPCS (Healthcare Common Procedure Coding System) procedure code J3490 (Unclassified drugs) on claims submitted to ForwardHealth for Synagis[®]. Claims submitted for Synagis[®] with HCPCS procedure code J3490 will be denied.

Topic #511

Weight Management Services

Weight management services (e.g., diet clinics, obesity programs, weight loss programs) are reimbursable only if performed by or under the direct, on-site supervision of a physician and only if performed in a physician's office. Weight management services exceeding five visits per calendar year require PA (prior authorization). Prescription drugs prescribed for weight loss also require PA. (The [Pharmacy service area](#) has additional information about prescription drug PA requirements.)

Submit claims for weight management services with the appropriate E&M (evaluation and management) procedure code. For weight management services, food supplements, and dietary supplies (e.g., liquid or powdered diet foods or supplements, OTC (over-the-counter) diet pills, and vitamins) that are dispensed during an office visit are not separately reimbursable by Wisconsin Medicaid.

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 the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, and Wisconsin Medicaid unless otherwise specified. Women enrolled in an HMO (health maintenance organization) 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). The EPDS is available in English, Spanish and Hmong at the [Perinatal Foundation/Wisconsin Association for Perinatal Care Web site](#).
- BDI-II (Beck Depression Inventory-II). The BDI-II is available for a fee through the [Harcourt Assessment, Inc., Web site](#).
- CES-D (Center for Epidemiologic Studies Depression Scale). The CES-D is available through the [Stanford Patient Education Research Center](#).
- The nine item depression scale of the PHQ-9 (Patient Health Questionnaire). The PHQ-9 is available through the [MacArthur Initiative on Depression and Primary Care Web site](#).

Substance abuse screening tools available to providers include the following:

- The 5-Ps Prenatal Substance Abuse Screen for Alcohol, Drugs, and Tobacco. The 5-Ps scale for pregnant women is available at the [Louisiana Department of Health and Hospitals Office for Addictive Disorders Web site](#).
- T-ACE (Tolerance, Annoyance, Cut down, Eye opener) screen. The T-ACE screen is available through the [Project Cork Web site](#).
- TWEAK (Tolerance, Worry, Eye opener, Amnesia, Cut down) screen. The TWEAK screen is available through the [Project Cork Web site](#).
- The ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test). This screen is available through the [WHO \(World Health Organization\) Web site](#).

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). The SBIRT protocols, designed to treat persons at risk of substance abuse problems, is available through the U.S. Department of Health and Human Services.
- My Baby & Me is a program that addresses alcohol cessation in pregnant women using specific intervention and counseling strategies. For more information about the My Baby & Me program, visit the [Wisconsin Women's Health Foundation Web site](#).

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 limited to one unit of service per member per pregnancy. A unit of service is equivalent to the total amount of time required to administer the screening. Providers are encouraged to use more than one screening tool during the screening process when appropriate.

The screening 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	Not allowed	Not allowed	Allowed

substance abuse clinics			
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.

Place of Service Codes (Submitted on the 1500 Health Insurance Claim Form)	
03	School
11	Office
12	Home
21*	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room / Hospital
99	Other Place of Service

Mental Health and Substance Abuse Screening and Preventive Counseling/Intervention Services for Pregnant Women					
Procedure Code	Description	Required Modifier	Limitations	Allowable ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) Diagnosis	Allowable Place of Service
H0002 Mental Health and Substance Abuse	Behavioral health screening to determine eligibility for admission to	HE (Mental health program) or HF	Limited to one unit per member per pregnancy.	V28.9 (Unspecified antenatal screening)	03, 11, 12, 21*, 22, 23, 99

Screening	treatment program (Unit equals one, regardless of time)	(Substance abuse program)			
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 date of service (DOS). A screening (H0002 with modifier "HE" or "HF") must be administered on or before the DOS for this procedure.	V65.4 (Other counseling, not otherwise specified)	03, 11, 12, 21*, 22, 23, 99

* Place of service code "21" is not allowed for substance abuse counselors and Master's-level mental health providers.

Noncovered Services

Topic #9337

Basic Plan Noncovered Services

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

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

Billing Members for Noncovered Services

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

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

Topic #68

Definition of Noncovered Services

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

Topic #567

Experimental Services

Wisconsin Medicaid does not cover services that are considered to be experimental in nature. A service is considered experimental when Wisconsin Medicaid determines that the procedure or service is not an effective or proven treatment for the condition for which it is intended.

Wisconsin Medicaid resolves questions relative to the experimental or nonexperimental nature of a procedure based on the following, as appropriate:

- The judgment of the medical community.
- The extent to which other health insurance sources cover a service.
- The current judgment of experts in the applicable medical specialty area.
- The judgment of a committee formed by the ERO (External Review Organization) at the request of Wisconsin Medicaid.

Topic #104

Member Payment for Noncovered Services

A provider may collect payment from a member for noncovered services if [certain conditions](#) are met.

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

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

Missed Appointments

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

Avoiding Missed Appointments

ForwardHealth offers the following suggestions to help avoid missed appointments:

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

Translation Services

Translation services are considered part of the provider's overhead cost and are not separately reimbursable. Providers may not

collect payment from a member, or authorized person acting on behalf of the member, for translation services.

Providers should call the Affirmative Action and Civil Rights Compliance Officer at (608) 266-9372 for information about when translation services are required by federal law. Providers may also write to the following address:

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

Obstetric Care

Topic #1260

An Overview

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

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

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

Topic #7757

Cesarean Sections

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

Elective Cesarean Sections

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

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

Refer to the [maximum allowable fee schedule](#) for current reimbursement rates.

Non-elective Cesarean Sections

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

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

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

Cesarean Section Procedure Codes That Do Not Require a Modifier

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

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

Topic #1257

Complications of Pregnancy

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

Topic #1254

Global Obstetric Care

Providers may submit claims using global obstetric codes. Providers choosing to submit claims for global obstetric care are required to perform all of the following:

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

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

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

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

Group Claims Submission for Global Obstetric Care

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

Topic #1253

Health Professional Shortage Area-Enhanced Reimbursement

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

Topic #1255

Member Enrollment

Services Provided Before the Member Was Enrolled in BadgerCare Plus

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

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

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

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

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

Topic #2615

Newborn Reporting

Physician services providers are required to report babies born to BadgerCare Plus members by following the [newborn reporting](#) procedures.

Topic #1270

Newborn Screenings

Wisconsin Medicaid covers the cost of prepaid filter paper cards in addition to the laboratory handling fee for newborn screenings

provided outside a hospital setting. Providers are required to submit paper claims for [newborn screenings](#).

Topic #1251

Separate Obstetric Care Components

Providers should use the following guidelines when submitting claims for separate obstetric components.

Note: A telephone call between a patient and a provider does not qualify as an office visit.

Antepartum Care

Antepartum care includes dipstick urinalysis, routine exams, and recording of weight, blood pressure, and fetal heart tones.

Providers should provide *all* antepartum care visits before submitting a claim to Wisconsin Medicaid.

Indicate CPT (Current Procedural Terminology) procedure codes 99204 with modifier "TH" (Obstetrical treatment/services, prenatal or postpartum) and 99213 with modifier "TH" when submitting claims for one to three total antepartum care visits with the same provider or provider group. For example, if a total of two or three antepartum care visits is performed during a woman's pregnancy, the provider should indicate procedure code 99204 with modifier "TH" and a quantity of "1.0" for the first DOS (date of service). For the second and third visits, the provider should indicate procedure code 99213 with modifier "TH" and a quantity of "1.0" or "2.0," as indicated in the table. The date of the last antepartum care visit is the DOS.

Similarly, for CPT codes 59425 (antepartum care only; 4-6 visits) and 59426 (antepartum care only; 7 or more visits), the provider should indicate the date of the last antepartum care visit as the DOS. The quantity indicated for these two codes may not exceed "1.0."

Antepartum Care Claims Submission Guide			
Total Visit(s)	Procedure Code and Description *	Modifier and Description	Quantity
1	99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity (45 minutes)	TH (Obstetrical treatment/services, prenatal or postpartum)	1.0
2	99204	TH	1.0
	99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity (15 minutes)	TH	1.0
3	99204	TH	1.0
	99213	TH	2.0
4-6	59425 Antepartum care only; 4-6 visits		1.0
7+	59426 7 or more visits		1.0

*Refer to the current CPT code book for a complete description of procedure codes 99204 and 99213.

Occasionally, a provider may be unsure of whether a member has had previous antepartum care with another provider. If the member is unable to provide this information, the provider should assume the first time he or she sees the member is the first antepartum visit.

Reimbursement for antepartum care (procedure codes 99204 with modifier "TH," 99213 with modifier "TH," 59425, and 59426) is limited to once per pregnancy, per member, per billing provider.

Delivery

Delivery includes patient preparation, placement of fetal heart or uterine monitors, insertion of catheters, delivery of the child and placenta, injections of local anesthesia, induction of labor, and artificial rupture of membranes.

A provider who performs a vaginal or cesarean delivery may submit a claim using the appropriate delivery code. A clinic or group may submit a claim for the delivery component separately and should indicate the provider who performed the delivery as the rendering provider, rather than the primary obstetric provider.

When there are multiple deliveries (e.g., twins), one claim should be submitted for all of the deliveries. On the first detail line of the claim, indicate the appropriate procedure code for the first delivery. Indicate additional births on separate detail lines of the claim form, using the appropriate delivery procedure code for each delivery, depending on whether it is an elective or nonelective cesarean section.

In cases where [surgical assistance](#) is medically necessary for a cesarean delivery, both surgeons should submit a claim with the appropriate procedure code.

Induction or Inhibition of Labor

Pitocin drip and tocolytic infusions are not separately reimbursable when provided on the date of delivery. Induction or inhibition of labor are only reimbursable when physician services are documented in the medical record and when performed on dates other than the delivery date. Submit a paper claim for the service indicating CPT code 59899 (Unlisted procedure, maternity care and delivery) with supporting clinical documentation attached.

Postpartum Care

Postpartum care includes all routine management and care of the postpartum patient including exploration of the uterus, episiotomy and repair, repair of obstetrical lacerations and placement of hemostatic packs or agents. These are part of both the post-delivery and post-hospital office visits, both of which must occur in order to receive reimbursement for postpartum care or global obstetric care.

In accordance with the standards of the American College of Obstetricians and Gynecologists, Medicaid reimbursement for postpartum care includes *both* the routine post-delivery hospital care *and* an outpatient/office visit. Post-delivery hospital care alone is included in the reimbursement for delivery. When submitting a claim for postpartum care, the DOS is the date of the post-hospital discharge office visit. In order to receive reimbursement, the member *must* be seen in the office.

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

Delivery and Postpartum Care

Providers who perform both the delivery and postpartum care may submit claims with either the separate delivery and postpartum

codes or the delivery including postpartum care CPT procedure codes 59410, 59515, 59614, or 59622, as appropriate. The DOS for the combination codes is the delivery date. However, if the member does not return for the postpartum visit, the provider is required to adjust the claim to reflect delivery only or the reimbursement will be recouped through an audit.

Topic #1250

Separately Reimbursable Pregnancy-Related Services

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

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

Topic #1248

Unrelated Conditions

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

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

Topic #1247

Unusual Pregnancies

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

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 the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, the BadgerCare Plus Basic Plan, 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 DHS (Department of Health Services) before using a tool that is not listed below. Contact the 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., Web site](#).
- The ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test). This screen is available through the [WHO Web site](#).
- 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 Web site](#). 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 Web site](#).

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 Medicaid or BadgerCare Plus Standard Plan, the screening is limited to one unit of service per rolling 12 months. For members enrolled in the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, and the BadgerCare Plus Basic Plan, the screening is limited to one unit of service per enrollment year. A unit of service is equivalent to the total amount of time required to administer the screening.

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

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

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

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

Substance Abuse Intervention

For members enrolled in Medicaid and the Standard Plan, the intervention services are limited to four hours per rolling 12 months. For members enrolled in the Benchmark Plan, the Core Plan, and the Basic Plan, the intervention services are limited to four hours per enrollment year. 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 BadgerCare Plus or Wisconsin Medicaid 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 or substance abuse clinics	Allowed when provided in conjunction with a primary care, hospital, 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 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. The 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)	
03	School
11	Office
12	Home
21	Inpatient Hospital
22	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 Standard Plan)	Limitations (BadgerCare Plus Benchmark Plan and BadgerCare Plus Core Plan)	Allowable Place of Service	Allowable Diagnosis Code
H0049	Alcohol and/or drug screening	Limited to one unit per member, per rolling 12 months.	Limited to one unit per member, per enrollment year.	03, 11, 12, 21, 22, 23, 99	V82.9
H0050	Alcohol and/or drug service, brief intervention, per 15 minutes	Limited to 16 units per member, per rolling 12 months.	Limited to 16 units per member, per enrollment year.	03, 11, 12, 21, 22, 23, 99	V65.42

Surgery Services

Topic #557

Abortions

Coverage Policy

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

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

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

Covered Services

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

Coverage of Mifeprex

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

When submitting claims for Mifeprex, providers are required to:

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

which the abortion is covered.

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

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

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

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

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

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

Services Incidental to a Noncovered Abortion

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

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

Topic #558

Anesthesia by Surgeon

Reimbursement for anesthesia provided by the surgeon (e.g., local infiltration, digital block, conscious sedation, topical anesthesia, regional anesthesia, and general anesthesia) is included in the Medicaid reimbursement for the surgical or diagnostic procedure(s) performed and is not separately reimbursable.

However, if the [anesthesia](#) is the primary procedure performed, for diagnosis or treatment, it is separately reimbursable. For example, if an intercostal nerve block is done for diagnosis and treatment of post-therapeutic neuralgia, and an epidural steroid injection procedure is also done, the anesthetic procedure is separately reimbursable.

Topic #559

Bariatric Surgery

[Bariatric surgery](#) is covered under certain circumstances with PA (prior authorization).

The following procedures are considered investigational, inadequately studied, or unsafe and therefore are not covered:

- Vertical banded gastroplasty.
- Gastric balloon.
- Loop gastric bypass.
- Open adjusted gastric banding.

Topic #560

Breast Reconstruction

Breast reconstruction requires PA (prior authorization); however, PA is *waived* for breast reconstruction when performed following a mastectomy for breast cancer. (Breast reconstruction is identified by CPT (Current Procedural Terminology) codes 19316-19325, 19340-19350, 19357-19369, 19380-19396.) This is pursuant to the federal Women's Health and Cancer Rights Act of 1998. Claims for breast reconstruction must include an ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis code for breast cancer (174.0-174.9, 175.0-175.9, 233.0, 238.3, 239.3) in order for the PA requirement to be waived by Wisconsin Medicaid.

Topic #572

Cataract Surgery

When a surgeon performs all of the components of cataract surgery, including preoperative, surgical, and postoperative care, the appropriate surgical procedure code should be indicated on the claim. Providers should follow the guidelines outlined here if another physician or an optometrist performs postoperative care.

Surgical Care Only

Submitting claims for surgical care only is allowed when one surgeon performs the cataract surgery and another provider delivers postoperative management. Surgical care only is identified by adding modifier "54" (Surgical care only) to the appropriate procedure code on the claim. Use of modifier "54" is allowed only for cataract surgery procedure codes 66820-66821, 66830-66984 for preoperative care and surgery when post-operative care is performed by an optometrist. Wisconsin Medicaid does not separately reimburse surgical care (modifier "54") for any other surgical procedure codes.

The following criteria apply when using modifier "54":

- The modifier is allowable only for the surgeon who performed the surgery.
- The surgeon is reimbursed at 80 percent of the global maximum allowable fee for performing the surgery.
- Wisconsin Medicaid will not reimburse more than what the global period allows for a given surgery. The sum of reimbursement for separately performed "surgical care only" and "postoperative management only" will not exceed the global maximum allowable fee for cataract surgery, regardless of the number of providers involved. Reimbursement may be reconciled in post-pay audit.
- Hospital inpatients: If cataract surgery is performed on a hospital inpatient, only the surgeon may submit claims for the appropriate cataract procedure codes with modifier "54." Any other provider who sees the member during the inpatient stay will be reimbursed only for medically necessary E&M (evaluation and management) procedures (e.g., 99232 [subsequent hospital care]).

Postoperative Management

Postoperative management for cataract surgery is allowed only when a physician or other qualified provider performs the postoperative management during the postoperative period after a different physician has performed the surgical procedure.

Modifier "55" (Postoperative management only) should be used with the appropriate cataract surgery procedure code when another provider delivers all or part of the postoperative management or when the surgeon provides a portion of the postoperative management. Use of modifier "55" is allowed only for cataract surgery procedure codes 66820-66821, 66830-66984 for postoperative care when performed by an optometrist. Wisconsin Medicaid does not separately reimburse postoperative management (modifier "55") for any other surgical procedure codes.

The following criteria apply when using modifier "55":

- Modifier "55" includes all postoperative visits performed by a provider. Quantity is limited to "1" per provider during the entire postoperative period.
- Wisconsin Medicaid will not reimburse more than the global maximum allowable fee for a given surgery, including postoperative management. The sum of reimbursement for separately performed "postoperative management only" and "surgical care only" will not exceed the global fee for cataract surgery, regardless of the number of providers involved. Reimbursement may be reconciled in post-pay audit.
- The provider is reimbursed at 20 percent of the global maximum allowable fee for providing postoperative management for major surgery.
- When two or more provider types (i.e., ophthalmologists, optometrists, or other qualified providers) split postoperative management, reimbursement will be reduced proportionately following post-pay review of the claims and/or medical records.
- The surgeon *and* all postoperative management providers are required to keep a copy of the written transfer agreement with the dates of relinquishment and assumption of care in their member's medical record.
- The dates that the postoperative management was provided as indicated on the claim must occur on and after those indicated on the transfer agreement. A claim with a DOS (date of service) prior to what was indicated on the transfer agreement will be denied during post-pay review and the reimbursement will be recouped.
- Wisconsin Medicaid does not require providers to submit additional supporting clinical documentation as part of the claims submission process for cataract surgery.

Preoperative Management

Preoperative management is included in the reimbursement rate for surgical care and is not separately reimbursable. Wisconsin Medicaid does not separately reimburse modifier "56" (Preoperative management only) when submitting claims for preoperative management.

Topic #578

Co-surgeons/Assistant Surgeons

Under certain circumstances, the expertise of two or more surgeons (usually, but not always, with different specialties) may be required and medically necessary in the management of specific surgical procedures. In these cases, both surgeons submit claims for the surgery code(s). Each surgeon is reimbursed at Wisconsin Medicaid's usual surgeon rate for the specific procedure he or she has performed. Additional supporting clinical documentation (such as an operative report) must be submitted with each surgeon's claim to demonstrate medical necessity and to identify the co-surgeons.

When two or more surgeons perform one or more procedures that are generally performed by a surgeon and an assistant (or assistants), the principal surgeon submits a claim for the surgery procedure code(s) and the additional surgeon(s) submits a claim for the surgery procedure code(s) with the appropriate modifier.

Following are CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) definitions of the accepted assistant surgeon modifiers:

- "80" — Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

- "81" — Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.
- "82" — Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).
- "AS" — Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery.

Reimbursement for Assistant Surgeon Services

ForwardHealth reimburses surgical assistance services at 20 percent of the reimbursement rate allowed for the provider type for the surgical procedure. To receive reimbursement for surgical assistance, indicate the surgery procedure code with the appropriate assistant surgeon modifier ("80," "81," "82," or "AS") on the claim.

ForwardHealth will automatically calculate the appropriate reimbursement for assistant surgeon services based on the provider type performing the procedure.

Topic #575

Contraceptive Implants

Contraceptive implant services and devices are covered. Providers should indicate the appropriate procedure code for the insertion or removal of the contraceptive implant and the appropriate procedure code for the implant device. Providers should not submit claims for E&M (evaluation and management) services associated with contraceptive implant services, unless another separate and distinct service is provided and documented in the member's medical record.

Informed Consent Procedure

ForwardHealth recommends that providers of implantable contraceptives have a fully informed consent procedure and present comprehensive information to members prior to the implantation procedure. This information should include the following:

- Physiological effects of contraceptive implants.
- Risks associated with implant use.
- Potential side effects.
- Recommendations for follow-up care and removal.

As part of the informed consent process, ForwardHealth recommends using information provided in the patient education materials supplied by the manufacturer. Members should be informed of the following considerations:

- Some patients may experience thick, permanent scarring of the skin at the insertion and removal site (keloid formation).
- Migration of the device may occur, making removal difficult.
- Women can request the implant be removed at any time.
- The implant does not provide protection against STDs (sexually transmitted diseases).

ForwardHealth recommends that informed consent be documented in the member's medical record and include the signatures or initials of both the provider and the member.

ForwardHealth recommends providing a waiting period between the education session and the insertion of the implant, as it may help ensure that a proper amount of time is allowed for an informed decision. Some providers indicate that this allows increased member acceptance of the implant. Such a waiting period may not always be acceptable, however, considering factors such as member preferences and limited transportation.

Topic #579

Dilation and Curettage

Providers are required to submit a paper claim for dilation and curettage. The claim must include additional supporting clinical documentation such as a preoperative history or physical exam report.

Topic #15577

Dorsal Column or Spinal Stimulator Implant Surgeries

Implantation of dorsal column (spinal cord) stimulators has been shown to provide benefit when treating chronic intractable pain in situations such as failed back surgery and complex pain syndromes. Because the procedure is invasive and has a significant complication rate, it should only be considered for conditions where evidence supports its efficacy and when more conservative methods have failed.

Dorsal column stimulator trials and surgeries require [PA \(prior authorization\)](#). Dorsal column stimulator trials and surgeries that do not meet the PA approval criteria are considered noncovered. Any charges related to the noncovered dorsal column stimulator surgeries will not be reimbursed.

A surgeon may receive separate reimbursement for the device if the surgery is performed in an outpatient hospital or ambulatory surgery center and the surgeon is Medicaid-enrolled as a DME (durable medical equipment) provider.

Topic #580

Foot Care

Wisconsin Medicaid covers the cleaning, trimming, and cutting of toenails once every 31 days (for one or both feet) if the member has one of the following systemic conditions:

- Arteriosclerosis obliterans evidenced by claudication.
- Cerebral palsy.
- Diabetes mellitus.
- Peripheral neuropathies involving the feet, which are associated with one of the following:
 - Malnutrition or vitamin deficiency.
 - Carcinoma.
 - Diabetes mellitus.
 - Drugs and toxins.
 - Multiple sclerosis.
 - Uremia.

Unna Boots

The application of unna boots is reimbursable for members with one of the following diagnoses:

- Varicose veins of lower extremities.
- Venous insufficiency, unspecified.
- Chronic ulcer of skin.
- Decubitus or other ulcer of lower extremity.
- Edema of lower extremities.

Reimbursement for the cost of the unna boot is included in the reimbursement for the application procedure.

Topic #12397

Gynecomastia Surgery

All [gynecomastia](#) procedures require PA (prior authorization). A gynecomastia procedure that does not meet the PA approval criteria is considered noncovered. Any charges related to the noncovered gynecomastia procedure will not be reimbursed.

Providers should use CPT (Current Procedural Terminology) procedure code 19300 (Mastectomy for gynecomastia) when submitting claims for gynecomastia surgery. Allowable ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis codes include the following:

- 611.1 — Hypertrophy of breast.
- 611.71 — Mastodynia.
- 758.7 — Klinefelter's syndrome.

Topic #581

Hysterectomies

An [Acknowledgment of Receipt of Hysterectomy Information \(F-01160 \(06/13\)\)](#) form must be completed prior to a covered non-emergency hysterectomy, except in the following circumstances:

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

If any of the above circumstances apply, providers are required to include signed and dated documentation (e.g., a copy of the preoperative history or physical exam or the operative report for a surgical procedure) with the claim.

Providers may [upload](#) the Acknowledgment of Receipt of Hysterectomy Information form via the Portal for electronically submitted claims or attach it to a paper 1500 Health Insurance Claim Form or UB-04 Claim Form.

Noncovered Services

ForwardHealth does not cover a hysterectomy for uncomplicated fibroids, a fallen uterus, or a retroverted uterus.

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

Topic #582

Intrauterine Devices

Wisconsin Medicaid reimburses physicians separately for the IUD (intrauterine device) and IUD insertion and removal procedures. Reimbursement for the E&M (evaluation and management) office visit and necessary supplies are included in the reimbursement for the IUD insertion and removal procedures. Do not submit a claim for the E&M visit or the supplies unless another separate and distinct service is provided and documented in the member's medical record.

Providers are required to indicate the appropriate [procedure code](#) on claims for IUD insertion and removal procedures.

Topic #12437

Pectus Excavatum/Carinatum Surgery

All [pectus excavatum/carinatum](#) procedures require PA (prior authorization). A pectus excavatum/carinatum procedure that does not meet the PA approval criteria is considered a noncovered service. Any charges related to the noncovered pectus excavatum/carinatum procedure will not be reimbursed.

Providers may be reimbursed for pectus excavatum/carinatum surgery using any of the following CPT (Current Procedural Terminology) procedure codes:

- 21740 — Reconstructive repair of pectus excavatum or carinatum; open.
- 21742 — Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thorascopy.
- 21743 — Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thorascopy.

Topic #586

Sterilizations

General Requirements

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

Providers should refer to the physician services [maximum allowable fee schedule](#) for allowable sterilization procedure codes.

Medicaid reimbursement for sterilizations is dependent on providers fulfilling all federal and state requirements and satisfactory completion of a [Consent for Sterilization \(F-01164 \(10/08\)\)](#) form. There are no exceptions. Federal and state regulations require the following:

- The member is not an institutionalized individual.
- The member is at least 21 years old on the date the informed written consent is obtained.
- The member gives voluntary informed written consent for sterilization.
- The member is not a mentally incompetent individual. Wisconsin Medicaid defines a "mentally incompetent" individual as a person who is declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purposes, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.
- At least 30 days, excluding the consent and surgery dates, but not more than 180 days, must pass between the date of

written consent and the sterilization date, except in the case of premature delivery or emergency abdominal surgery if:

- o In the case of premature delivery, the sterilization is performed at the time of premature delivery *and* written informed consent was given at least 30 days before the expected date of delivery *and* at least 72 hours before the premature delivery. The 30 days excludes the consent and surgery dates.
- o The sterilization is performed during emergency abdominal surgery *and* at least 72 hours have passed since the member gave written informed consent for sterilization.

Consent for Sterilization Form

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

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

The completed consent form can be uploaded via the ForwardHealth Portal for electronically submitted claims or be attached to a paper 1500 Health Insurance Claim Form to obtain reimbursement.

Retroactive Eligibility

If one or more of the federal requirements has not been met, including completing the consent form at least 30 days prior to the procedure, the sterilization service is considered not covered and the provider may not receive ForwardHealth reimbursement; however, the provider may bill the member. This policy applies to the sterilization procedure and any services related to the procedure.

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

Sterilization with Placement by Permanent Implant

The professional service for CPT (Current Procedural Terminology) procedure code 58565 (Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants) and the implantable device are reimbursed under separate procedure codes.

The professional service only is reimbursed under procedure code 58565. The implantable device is reimbursed under HCPCS (Healthcare Common Procedure Coding System) procedure code A4264 (Permanent implantable contraceptive intratubal occlusion device[s] and delivery). Providers are required to bill their usual and customary fee for services provided to Wisconsin Medicaid and BadgerCare Plus members.

Providers are required to complete and submit the Consent for Sterilization form when billing these services.

Topic #587

Temporomandibular Joint Surgery

Providers may submit claims for assessing TMJ (temporomandibular joint) dysfunction using an E&M (evaluation and management) visit procedure code. A TMJ office visit generally consists of the following for a member experiencing TMJ dysfunction:

- Comprehensive history.
- Detailed and extensive clinical examination.

- Diagnosis.
- Treatment planning.

Allowable Procedure Codes

Providers may refer to the [maximum allowable fee schedules](#) for the most current TMJ surgery and anesthesia services procedure codes.

Member Eligibility for Temporomandibular Surgery

A member must have received appropriate nonsurgical treatment that has not resolved or improved the member's condition to be considered eligible for TMJ surgery. Nonsurgical treatment may include the following:

- Short-term medication.
- Home therapy (e.g., soft diet).
- Splint therapy.
- Physical therapy, including correction of myofunctional habits.
- Relaxation or stress management techniques.
- Psychological evaluation or counseling.

Prior Authorization Requirements

Wisconsin Medicaid requires PA (prior authorization) for TMJ surgery.

The surgeon who will perform the TMJ surgery requests PA by using the [PA/RP \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#), the [PA/PA \(Prior Authorization/Physician Attachment, F-11016 \(07/12\)\)](#), and supporting documentation, including, but not limited to:

- Documentation describing all prior nonsurgical treatments, treatment dates, and treatment outcomes.
- The type of surgical procedure being considered.

Only TMJ surgeries with favorable prognosis for surgery are considered for approval.

If a member is enrolled in a Medicaid HMO (health maintenance organization) or SSI (Supplemental Security Income) HMO, the Medicaid HMO or SSI HMO may require a multi-disciplinary evaluation and will be responsible for payment of all medical costs related to the evaluation.

In addition, the Medicaid HMO or SSI HMO (not Medicaid fee-for-service) is responsible for paying the cost of all related medical and hospital services. The Medicaid HMO or SSI HMO may, therefore, designate the facility where the surgery will be performed. Physicians are required to participate in or obtain a referral from the member's HMO or SSI HMO, since the HMO or SSI HMO is responsible for paying the cost of all services. Failure to obtain an HMO or SSI HMO referral may result in a denial of payment for services by the HMO or SSI HMO.

Topic #584

Transplant Services

The following transplants are covered when they are appropriate and medically necessary and are provided in an approved hospital as determined by ForwardHealth:

- Cornea.

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

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

Transplants must be performed in an approved UNOS (United Network for Organ Sharing) transplant center. Refer to the Data page of the [Organ Procurement and Transplantation Network](#) for UNOS-approved organ transplant centers.

Prior to making a referral to an approved transplant center, ForwardHealth recommends that physicians verify that the transplant center currently accepts Wisconsin Medicaid member referrals and Medicaid reimbursement for the proposed transplant.

Prior Authorization Requirements

For [transplant services that require PA](#), the transplant center in which the transplant will occur is required to request PA, *not* the physician. The transplant center and the physician are encouraged to jointly complete the PA request.

Topic #588

Vagus Nerve Stimulator Implant Surgeries

VNS (Vagus nerve stimulation) is a safe and effective treatment for members with medical refractory partial onset seizures for whom other surgery is not an option or for whom surgery has failed.

[VNS](#) implant surgeries require PA (prior authorization). The rendering surgeon is required to obtain PA from Wisconsin Medicaid. Wisconsin Medicaid will deny claims for services and equipment related to the surgery unless there is an approved PA request on file from the rendering surgeon for the surgery. VNS implant surgeries that do not meet the PA approval criteria are considered noncovered. Any charges related to the noncovered VNS implant surgery will not be reimbursed.

The surgeon may receive separate reimbursement for the device if the surgery is performed in an outpatient hospital or ambulatory surgery center *and* the surgeon is Medicaid-enrolled as a DME (durable medical equipment) provider.

EHR Incentive Program

4

Archive Date:01/02/2014

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

Topic #12102

Adopting EHR Technology

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

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

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

Topic #12103

Implementing EHR Technology

In order to qualify for a Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payment under "implementation," Eligible Professionals and Eligible Hospitals must meet the criteria for adopting certified EHR technology and demonstrate actual implementation, installation, or utilization of certified EHR technology. Examples of how to demonstrate implementation of certified EHR technology includes completing a workflow analysis and redesign, training staff on the use of modules, and patient demographics and administrative data. All information is subject to audit at any time and must be maintained by the Eligible Professional or Eligible Hospital for a period of six years. If selected for audit, the applicant must be able to supply at least one document from each of the following lists:

List One:

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

List Two:

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

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

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

Topic #12104

Upgrading EHR Technology

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

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

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

Topic #12497

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

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

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

An Overview

Topic #12037

Overview of the EHR Incentive Program

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

Under the federal law, Medicare and Medicaid have separate EHR incentive programs. Eligible Professionals may register to participate in either the Medicare or Medicaid EHR Incentive Programs, but not both. Eligible Professionals may change their EHR Incentive Program election once, switching between Medicare and Medicaid, but the change in election must occur on or before December 31, 2014. All Eligible Professionals must be Wisconsin Medicaid-enrolled in order to participate in the Wisconsin Medicaid EHR Incentive Program. Eligible Professionals may participate in only one state's Medicaid EHR Incentive Program. Eligible Professionals should apply for EHR payments from the state with which they do most of their business.

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

Payments to Eligible Professionals will be made within 45 calendar days of the approval of a completed and submitted application. Eligible Professionals who meet all of the requirements may receive an incentive payment once per calendar year.

The Wisconsin Medicaid EHR Incentive Program will be available for Eligible Professionals from 2011 through 2021. The last date Eligible Professionals may register to begin receiving incentive payments for adopting, implementing, and upgrading EHR technology is December 31, 2016. Eligible Professionals may participate for a total of six years in the Wisconsin Medicaid EHR Incentive Program. Eligible Professionals are encouraged, but not required, to participate in all six allowed payment years.

The Wisconsin Medicaid EHR Incentive Program payment years are defined as calendar years and are composed in the following way:

- First payment year: Eligible Professionals are required to attest to adopting, implementing, or upgrading certified EHR technology.
- Second payment year: Eligible Professionals are required to demonstrate "meaningful use" of certified EHR technology during any 90-day, continuous period during the payment year.
- Third — sixth payment year: Eligible Professionals are required to demonstrate "meaningful use" of certified EHR technology for the entire payment year.

Eligible Professionals will have an additional 90-day grace period after the end of the Program Year to apply for an incentive payment for that Program Year. The Program Year for Eligible Professionals is based on the calendar year (i.e., January 1 - December 31).

Eligible Professionals should note that they are not required to participate in consecutive years of the Wisconsin Medicaid EHR Incentive Program. For example, an Eligible Professional may register and complete all requirements for the first year in 2011 and receive a payment but then wait until 2013 to demonstrate "meaningful use" during a 90-day, continuous period for the second payment year.

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

Appeals

Topic #12137

Appeals Process

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

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

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

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

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

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

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

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

Topic #12477

Valid Reasons to Appeal

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

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

Appealing a Payment Amount

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

Appealing a Denied Wisconsin Medicaid Electronic Health Record Incentive Program Application

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

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

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

Denied Application Appeals	
Reason for Appeal	Documentation Needed
The patient volume required by the CMS (Centers for Medicare and Medicaid Services) have not been met, see federal rule 42 CFR 495.304.	<ul style="list-style-type: none"> • For Eligible Hospitals, provide the out-of-state patient volume for the reported 90-day period on the Wisconsin Medicaid EHR Incentive Program application. • For Eligible Professionals, provide the patient volume for the reported 90-day period on the Wisconsin Medicaid EHR Incentive Program application.
The Eligible Hospital has indicated it is not an acute care hospital with an average length of stay of 25 days or less or a children's hospital.	Acute care and children's hospitals are required to have an average length of stay for patients of 25 days or less to qualify for the Wisconsin Medicaid EHR Incentive Program. If the question was answered incorrectly when completing the original Wisconsin Medicaid EHR Incentive Program application, provide a clarifying statement indicating the reason why the Eligible Hospital meets the requirements for the program.
The Eligible Hospital did not confirm to only participate in the Wisconsin Medicaid EHR Incentive Program.	Eligible Hospitals must agree to participate in only one state's Medicaid EHR Incentive Program. If the question was answered incorrectly when completing the original Wisconsin Medicaid EHR Incentive Program application, provide a clarifying statement that the Eligible Hospital confirms to only participate in the Wisconsin Medicaid EHR Incentive Program.

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

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

Eligibility

Topic #12038

Eligible Professionals for EHR Incentive Program

To be eligible to participate in the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program, an Eligible Professional must be enrolled in Wisconsin Medicaid as one of the following:

- Advanced practice nurse prescriber with psychiatric specialty.
- Dentist.
- Nurse midwife.
- Nurse practitioner.
- Physician.
- PAs (physician assistants). Only PAs practicing in an FQHC (federally qualified health center) or RHC (rural health clinic) are considered Eligible Professionals.

Note: Under the federal law, only PAs practicing in an FQHC or RHC that is so led by a PA are considered Eligible Professionals. "So led" is defined in the federal regulation as one of the following:

- When a PA is the primary provider in a clinic.
- When a PA is a clinical or medical director at a clinical site of practice.
- When a PA is an owner of an RHC.

Eligible Professionals who are able to demonstrate that they funded the acquisition of the CEHRT (Certified Electronic Health Record Technology) they are using without reimbursement from an Eligible Hospital and provide more than 90 percent of their services in POS (place of service) 21 (Inpatient Hospital) or 23 (Emergency Room — Hospital) are eligible to participate in the Wisconsin Medicaid EHR Incentive Program. Hospital-based Eligible Professionals are required to upload one of the following documents as part of the application process:

- Receipt or proof of purchase detailing the CEHRT, including the vendor, product, and version number.
- Contract or lease detailing the CEHRT, including the vendor, product, and version number.

Financial Information

Topic #12120

835 Health Care Claim Payment/Advice Transaction

To assist trading partners in identifying Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payments received for an Eligible Professional or organizations on the 835 (835 Health Care Claim Payment/Advice) transaction, the NPI (National Provider Identifier) of the Eligible Professional approved to receive the Wisconsin Medicaid EHR Incentive Program payment will appear in segment PLB01 of the 2110 Loop. The PLB03-1 segment identifies the adjustment reason code. A code of LS will represent a positive incentive payment while a code of WO will represent a recovery of a previously paid incentive payment. The PLB04 segment will represent the monetary amount that is either paid or recouped based on the Adjustment Reason Code displayed in PLB03-1.

Topic #12118

Electronic Funds Transfer

Eligible Professionals who assign payments to themselves as individuals may elect to receive paper checks but are encouraged to set up an EFT (electronic funds transfer). EFTs allow ForwardHealth to directly deposit payments into the group's or Eligible Professional's designated bank account for a more efficient delivery of payments. An EFT is secure, eliminates paper, and reduces the uncertainty of possible delays in mail delivery.

Eligible Professionals that assign payments to an organization or clinic must supply the organization's EFT number. Organizations receiving payment from an Eligible Professional may only receive incentive payments through their existing EFT account.

Refer to the Electronic Funds Transfer User Guide on the [Portal User Guides page](#) of the Portal for information on EFT enrollment.

Topic #12117

Example of a Six-Year Payment Schedule for an Eligible Professional

Eligible Professionals who complete all the requirements for each applicable payment year will receive incentive payments in lump sums, as listed in the following table. Eligible Professionals may begin registering for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program beginning in 2011 and up until 2016.

Calendar Year	Wisconsin Medicaid Eligible Professionals*					
	2011	2012	2013	2014	2015	2016
2011	\$21,250	—	—	—	—	—
2012	\$8,500	\$21,250	—	—	—	—
2013	\$8,500	\$8,500	\$21,250	—	—	—
2014	\$8,500	\$8,500	\$8,500	\$21,250	—	—

2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	—
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017	—	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018	—	—	\$8,500	\$8,500	\$8,500	\$8,500
2019	—	—	—	\$8,500	\$8,500	\$8,500
2020	—	—	—	—	\$8,500	\$8,500
2021	—	—	—	—	—	\$8,500
Total	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

*Pediatricians with a minimum of 20 percent eligible member patient volume, but less than 30 percent eligible member patient volume will receive two-thirds of the incentive payment amounts. Eligible pediatricians will receive \$14,167 in their first payment year, \$5,667 in their second payment year, and \$42,500 in their third through sixth payment years.

Topic #12105

Incentive Payment Information

Eligible Professionals who meet all of the requirements will receive an incentive payment once per calendar year. Eligible Professionals must assign payment to either themselves or their organization's federal TIN (tax identification number).

Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payments for Eligible Professionals may only be assigned to either the Eligible Professional themselves or the group practice assigned for the pay-to address on the Wisconsin Medicaid provider file. Eligible Professionals should ensure that the most current group practice is assigned for the pay-to address. Eligible Professionals can check this information via their ForwardHealth Portal Account in the "Demographic" section.

Topic #12119

Remittance Advice

Financial Transactions Section

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

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

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

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

Summary Section

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

Meaningful Use of Certified EHR Technology

Topic #13357

Definition of Meaningful Use

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

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

- The use of a certified EHR in a meaningful manner, such as e-prescribing.
- The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
- The use of certified EHR technology to submit clinical quality and other measures.

In short, meaningful use means Eligible Professionals need to demonstrate that they are using EHR technology in ways that can be measured in quality and quantity.

Topic #13358

Electronic Health Record Reporting Period for Meaningful Use

The EHR (Electronic Health Record) Reporting Period is defined as the timeframe when Eligible Professionals report meaningful use to the Wisconsin Medicaid EHR Incentive Program. The EHR Reporting Period years are defined as:

- First year: The Eligible Professional must be able to show meaningful use for a 90-day timeframe that falls within the Calendar Year that the Eligible Professional is applying for a Wisconsin Medicaid EHR Incentive Program payment. For example, if an Eligible Professional is applying for the 2012 Wisconsin Medicaid EHR Incentive Program payment, the entire 90-day reporting period must fall in Calendar Year 2012.
- Subsequent years: The Eligible Professional must be able to show meaningful use for the entire Calendar Year for which the Eligible Professional is applying for the Wisconsin Medicaid EHR Incentive Program payment. For example, if an Eligible Professional is applying for the 2013 Wisconsin Medicaid EHR Incentive Program payment, the reporting period must be January 1, 2013, through December 31, 2013.

Topic #13417

Eligible Professional Stage 1 Meaningful Use Supporting Documentation

The table below contains examples of supporting documentation an Eligible Professional (EP) would be expected to provide if selected for an audit of an application submitted for the Wisconsin Medicaid EHR Incentive Program under stage 1 meaningful use.

Example #	Requirement	Measure	Examples of Supporting Documentation
1	Must report and meet the required threshold/answers for all General Requirements and Core Measures	EPGMU 01-02 EPCMU 01-15	<ul style="list-style-type: none"> Meaningful Use Reports/Dashboard produced by Certified EHR Technology (CEHRT) Documentation on how the attestations were created, specifically how the numerator/ denominators were calculated, including rationale taken into account for inclusion/exclusion of data
2	EPGMU 01: Percent of CEHRT Use	Must have 50 percent or more of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology	<ul style="list-style-type: none"> List of total encounters with detail including date, patient identifier, payer, and rendering provider List of encounters with CEHRT, with detail on location and CEHRT used
3	EPGMU 02: Unique Patients in CEHRT	Must have 80 percent or more of their unique patient data in the certified EHR during the EHR reporting period	<ul style="list-style-type: none"> List of all unique patients with indication of whether in CEHRT. If practicing at multiple locations, indicate which patients seen in what location
4	EPCMU 01: Computerized physician order entry (CPOE)	Must have at least one medication order entered using CPOE for more than 30 percent of all unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period	<ul style="list-style-type: none"> Access to a random sampling of patient records Rationale for exclusion/ inclusion of patient records
5	EPCMU 02: Drug-drug and drug-allergy interaction checks	Must have enabled functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period	<ul style="list-style-type: none"> Audit log showing it is enabled for this functionality with time/date stamp
6	EPCMU 03: Maintain an up-to-date problem list of current and active diagnoses	Must have at least one entry (or an indication that no problems are known for the patient) recorded as structured data for more than 80 percent of all unique patients seen by the EP during the EHR reporting period	<ul style="list-style-type: none"> Access to a random sampling of patient records
7	EPCMU 04: E-Prescribing (eRx)	Must have used the certified EHR technology to transmit prescriptions electronically for more than 40 percent of all permissible prescriptions written by the EP during the EHR reporting period	<ul style="list-style-type: none"> Access to a random sampling of patient records Rationale for exclusion/inclusion of patient records Rationale for exclusion/inclusion of prescriptions
8	EPCMU 05: Maintain	Must have at least one active	<ul style="list-style-type: none"> Access to a random sampling of

	active medication list	medication entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data for more than 80 percent of all unique patients seen by the EP during the EHR reporting period	<p>patient records</p> <ul style="list-style-type: none"> • Rationale for exclusion/inclusion of patient records
9	EPCMU 06: Maintain active medication allergy list	Must have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data for more than 80 percent of all unique patients seen by the EP during the EHR reporting period	<ul style="list-style-type: none"> • Access to a random sampling of patient records
10	EPCMU 07: Record demographics	Must have demographics recorded as structured data for more than 50 percent of all unique patients seen by the EP during the EHR reporting period	<ul style="list-style-type: none"> • Access to a random sampling of patient records
11	EPCMU 08: Record and chart changes in vital signs	Must have height, weight, and blood pressure recorded as structured data for more than 50 percent of all unique patients age 2 and over seen by the EP during the EHR reporting period	<ul style="list-style-type: none"> • Access to a random sampling of patient records • Rationale for exclusion/ inclusion of patient records
12	EPCMU 09: Record smoking status for patients 13 years or older	Must have smoking status recorded as structured data for more than 50 percent of all unique patients 13 years old or older seen by the EP during the EHR reporting period	<ul style="list-style-type: none"> • Access to a random sampling of patient records • Rationale for exclusion/ inclusion of patient records
13	EPCMU 10: Report ambulatory clinical quality measures to CMS/states	Must successfully report to Wisconsin the ambulatory clinical quality measures selected by CMS in the manner specified by Wisconsin	<ul style="list-style-type: none"> • Audit log showing the enabling of this functionality with time/date stamp
14	EPCMU 11: Implement one clinical decision support rule	Must implement one clinical decision support rule	<ul style="list-style-type: none"> • Rationale for clinical decision support rule implemented • Audit log showing the enabling of this functionality with time/date stamp
15	EPCMU 12: Provide patients with an electronic copy of their health information upon request	Provide an electronic copy of health information to more than 50% of patients who request it within 3 business days.	<ul style="list-style-type: none"> • EP Policy and Procedure documentation • Rationale for exclusion/inclusion of patient records
16	EPCMU 13: Provide clinical summaries for patients for each office visit	Must have provided clinical summaries to patients for more than 50 percent of all office visits within 3 business days.	<ul style="list-style-type: none"> • Rationale for exclusion/ inclusion of patient records • Sample of Clinical Summary
17	EPCMU 14: Capability to	Must have performed at least one	<ul style="list-style-type: none"> • Detail of exchange of key clinical

	exchange key clinical information among providers of care and patient-authorized entities electronically	test of CEHRT's capacity to electronically exchange key clinical information.	information including, but not limited to: date, time, entity with which exchange took place (including contact information), and method of transportation for the exchange (include information on HIE used if applicable)
18	EPCMU 15: Protect electronic health information	Must conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), implement security updates as necessary, and correct identified security deficiencies as part of its risk management process.	<ul style="list-style-type: none"> Detail on security risk analysis including, but not limited to: approach for assessment, results of the assessment, indication of who performed the assessment Detail on security update performed as a result of the security risk analysis including, but not limited to: update made, date made
19	Must report and meet the required threshold/answers for 5 of the 10 Menu Measures with at least one measure being classified as a public health measure (EPMMU 09 or EPMMU 10)	EPMMU 01 -EPMMU 10	<ul style="list-style-type: none"> Meaningful Use Reports/ Dashboard produced by CEHRT Documentation on how the attestations were created, specifically how the numerator/denominators were calculated, including rationale taken into account for inclusion/exclusion of data
20	EPMMU 01: Drug-formulary checks	Must have enabled Drug- formulary check functionality and have access to at least one internal or external formulary for the entire EHR reporting period	<ul style="list-style-type: none"> Audit log showing the enabling of this functionality with time/date stamp
21	EPMMU 02: Incorporate clinical lab test results as structured data	Must have incorporated in CEHRT as structured data, more than 40 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format	<ul style="list-style-type: none"> Access to a random sampling of patient records
22	EPMMU 03: Generate lists of patients by specific conditions	Must generate at least one report listing patients of the EP with a specific condition	<ul style="list-style-type: none"> Rationale/reason for the list being generated with detail on the specific condition addressed Rationale for exclusion/inclusion of patient records
23	EPMMU 04: Send reminders to patients per patient preference for preventive/follow up care	Must have sent an appropriate reminder during the EHR reporting period to more than 20 percent of all patients 65 years or older or 5 years old or younger.	<ul style="list-style-type: none"> Access to a random sampling of patient records Rationale for exclusion/ inclusion of patient records
24	EPMMU 05: Provide	Must have provided timely	<ul style="list-style-type: none"> Access to a random sampling of

	patients with timely electronic access to their health information	(available to the patient within four business days of being updated in the certified EHR technology) electronic access to health information (subject to the EP's discretion to withhold certain information) for at least 10 percent of all unique patients seen by the EP during the EHR reporting period	<p>patient records</p> <ul style="list-style-type: none"> • Rationale for exclusion/ inclusion of patient records
25	EPMMU 06: Use CEHRT to identify patient-specific education resources and provide to patient, if appropriate	Must have provided patient-specific education resources to more than 10 percent of all unique patients seen by the EP during the EHR reporting period	<ul style="list-style-type: none"> • Documentation of patient-specific education resources that are provided to patients
26	EPMMU 07: Medication reconciliation	Must perform medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP during the EHR reporting period	<ul style="list-style-type: none"> • Access to a random sampling of patient records • Rationale for exclusion/ inclusion of patient records
27	EPMMU 08: Summary of care record for each transition of care/ referrals	Must provide a summary of care record for more than 50 percent of transitions of care and referrals of patients to another setting of care or provider of care during the EHR reporting period	<ul style="list-style-type: none"> • Access to a random sampling of patient records • Rationale for exclusion/ inclusion of patient records
28	EPMMU 09: Capability to submit electronic data to immunization registries/systems*	Must have performed at least one test of CEHRT's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically).	<ul style="list-style-type: none"> • Detail on test date and time
29	EPMMU 10: Capability to provide electronic syndromic surveillance data to public health agencies*	Performed at least one test of CEHRT's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically).	<ul style="list-style-type: none"> • Detail on test date and time • Wisconsin Public Health Letter qualifying EP for exclusion

Topic #13377

Meaningful Use Criteria Overview

CMS (Centers for Medicare and Medicaid Services) has split the meaningful use criteria into three stages that will be rolled out over the course of the next five years. Currently, the stages are identified as follows:

- Stage 1 sets the baseline for electronic data capture and information sharing.
- Stages 2 and 3 will continue to expand on this baseline and be developed through future rule making.

Requirements for Stage 1 of Meaningful Use

The requirements for stage 1 of meaningful use include both a "core set" and a "menu set" of objectives that are specific to Eligible Professionals. There are a total of 23 meaningful use objectives. To qualify for a Wisconsin Medicaid EHR Incentive Program payment, 18 of the 23 meaningful use objectives must be met. Of the 23 objectives, there are 13 required "core set" objectives that must be met. The remaining five "menu set" objectives may be chosen from a list of ten menu set objectives, of which two are Public Health measures. In addition to reporting 18 meaningful use objectives, Eligible Professionals must report from a table of 44 CQMs (clinical quality measures), which include three Core or three Alternate Core and 38 additional CQMs.

Some meaningful use objectives are not applicable to every Eligible Professional's clinical practice; therefore, no patients or actions would be eligible for the measure denominator. In these cases, the Eligible Professional would be excluded from having to meet that measure. For example, core measure nine of 13 is to "Record smoking status for patients 13 years old or older." An Eligible Professional who does not see patients 13 years or older may select the exclusion to this measure.

Eligible Professionals should refer to the CMS [Web page](#) for a complete table of contents of all core set and menu set objectives. Each objective contains the following information:

- The definition of the objective.
- How to measure the objective.
- Any applicable exclusions.

Additional information may also be included on this Web page regarding the following:

- Term definitions.
- Attestation requirements.
- Any other additional information related to the objective.
- Frequently asked questions.

Clinical Quality Measures

Clinical quality measures are tools that help measure or quantify health care processes, outcomes, patient perceptions, organizational structures, and systems that are associated with the ability to provide high-quality health care. To demonstrate meaningful use successfully, Eligible Professionals must report CQMs. Eligible Professionals must report on at least six measures: three from the Core Set of Clinical Quality Measures or from the Alternate Core Set if unable to report on any of the Core Set, and three from the 38 Additional Set of Clinical Quality Measures.

Eligible Professionals should refer to the CMS [Web page](#) for complete information on reporting clinical quality measures.

Public Health Meaningful Use Measures

Two of the 10 stage 1 meaningful use menu set requirements for Eligible Professionals specify electronic transmission of the following data to Public Health:

- Immunizations.
- Syndromic surveillance.

Eligible Professionals must meet five of the menu set requirements, one of which must be a public health requirement. If an Eligible Professional can be excluded from the requirements of both public health measures, the Eligible Professional may only select one of the public health measures, but not both, for attestation. Selecting both for an exclusion will not be permitted in this scenario. If an Eligible Professional can meet the requirements of one public health measure but can be excluded from the other, both measures may be selected for attestation.

The DPH (Division of Public Health) Wisconsin Immunization Program is presently able to conduct testing with Eligible Professionals for data submission of immunizations. The measure for validation of stage 1 public health meaningful use requires only that a single test be conducted. If multiple Eligible Professionals are using the same certified EHR technology in a shared physical setting, the test only has to be conducted once for the physical setting, not once for each Eligible Professional at the location. The Eligible Professional or location should institute ongoing data submission if the Wisconsin Immunization Program acknowledges a successful test. If the test is unsuccessful, the Eligible Professional or Eligible Professionals at the location will still satisfy the requirements of this measure for meaningful use. The Wisconsin Immunization Program will continue to work with the Eligible Professional or location to achieve a successful test to enable ongoing data submission.

The DPH is not presently accepting the submission of syndromic surveillance data from Eligible Professionals and will not be capable of accepting this data or testing with Eligible Professionals in 2012. An Eligible Professional may request a letter from DPH indicating DPH's lack of capability to accept syndromic surveillance data submissions. If the Eligible Professional selects this measure, DPH recommends the Eligible Professional follow the attestation instructions and guidance from CMS for claiming an exclusion. Deciding to attest on this measure assumes the Eligible Professional could also take an exclusion on the immunization data submission and has selected this public health measure for exclusion instead; or has selected both measures for attestation and was able to conduct a test submission of immunization data.

Eligible Professionals should refer to the Wisconsin DHS [Web site](#) for more information regarding Public Health meaningful use.

Responses for Meaningful Use Measures

Eligible Professionals will have three different types of responses to meaningful use measures:

- Yes or No.
- Attest to exclusions (any measure not applicable to the Eligible Professional's practice).
- Numerators and Denominators.

Numerators and Denominators

When entering percentage-based measures, the calculation to determine the meaningful use numerator and denominator will vary by measure. Eligible Professionals should refer to CMS Stage 1 EHR Meaningful Use Specification Sheets for Eligible Professionals for clear definition of meaningful use numerator and denominator prior to completing the Wisconsin Medicaid EHR Incentive Program application. Meaningful use numerators and denominators include the number of patients relevant as defined in the Specification Sheets and not just Medicare and Medicaid patients.

Eligible Professionals should refer to the CMS Stage 1 EHR Meaningful Use [Specification Sheets](#).

Eligible Professionals should refer to their EHR system for meaningful use denominators to be entered into the Wisconsin Medicaid EHR Incentive Program application. Eligible Professionals should note that each EHR system varies.

Meaningful Use Supporting Documentation

All information is subject to audit at any time and must be maintained by Eligible Professionals for a period of six years. If selected

for an audit, the applicant must be able to supply supporting documentation.

Topic #13397

Stages of Meaningful Use of Certified EHR Technology

The table below demonstrates what stage of meaningful use must be reported based upon the first year an Eligible Professional began participation in the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. Eligible Professionals should note that they do not need to participate in consecutive Program Years.

First Year of Participation	Program Year				
	2011	2012	2013	2014	2015
2011	AIU (adoption, implementation or upgrade)/Stage 1 MU (meaningful use)	Stage 1	Stage 2	Stage 2	TBD
2012		AIU/Stage 1 MU	Stage 1	Stage 2	TBD
2013			AIU/Stage 1 MU	Stage 1	TBD
2014				AIU/Stage 1 MU	TBD

Patient Volume

Topic #12098

Eligible Member Patient Volume

The federal law 42 CFR s. 495.306(c)(1) stipulates that only certain services rendered to certain members that are reimbursed with Medicaid (Title XIX) funds may be counted towards eligible member patient volume requirements. The Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program defines eligible members as those members enrolled in the programs listed [here](#).

Eligible Professionals using the eligible member patient volume method must meet a minimum patient encounter volume threshold of one of the following:

- At least 30 percent of their patient volume attributed to eligible members over a continuous 90-day period in the calendar year preceding the payment year.
- Pediatricians will be considered eligible if 20 percent of their patient encounter volume is attributable to eligible members but will receive two-thirds of the incentive amounts. If a pediatrician's patient encounter volume is 30 percent or higher, the incentive payments are the same as any other Eligible Professional.

Note: Eligible Professionals should note that the Wisconsin Medicaid EHR Incentive Program will not round up to meet the minimum patient volume threshold. All patient volumes reported that are below 30 percent (including those at or below 29.99 percent) will be deemed ineligible.

An eligible member patient encounter is defined as any services rendered on any one day to an individual enrolled in a Medicaid program. The Wisconsin Medicaid EHR Incentive Program will consider a claim paid at \$0 or more for services rendered on any one day to an individual enrolled in a Medicaid program to be an eligible member patient encounter.

Multiple Eligible Professionals may count an encounter for the same individual. For example, it may be common for a PA (physician assistant) or nurse practitioner and physician to provide services to a patient during an encounter on the same DOS (date of service). It is acceptable in these and similar circumstances to count the same encounter for multiple Eligible Professionals for purposes of calculating each Eligible Professional's patient volume. The encounters must take place within the scope of practice for each of the Eligible Professionals.

Eligible Professionals may be unable to distinguish between some eligible members and some non-eligible members when determining their patient volume. The Wisconsin Medicaid EHR Incentive Program only considers services provided to members that are reimbursed with funding directly from Medicaid (Title XIX) as a patient encounter. Eligible Professionals may be unable to determine where funding for eligible members comes from, so in order to assist Eligible Professionals in determining their eligible patient encounters, the Wisconsin Medicaid EHR Incentive Program will calculate a standard deduction. The standard deduction for 2013 is 8.01 percent.

To figure out the eligible member patient encounters, the Eligible Professional must multiply the total eligible member encounter patient volume by a factor of $(1 - .0801)$ or 0.9199 and then divide that number by the total eligible member patient encounter volume. The final number should be rounded to the nearest whole number (i.e., .01 through .49 should be rounded down and .50 through .99 should be rounded up to the nearest number.)

Eligible Professionals using the eligible member patient volume method may elect to calculate patient volume at the individual or group practice level. If an Eligible Professional calculates his or her patient encounter volume based on a group practice level, the entire group practice's patient encounter volume must be included. This includes the services rendered by all providers within the

group practice, regardless of provider type or eligibility status for the Wisconsin Medicaid EHR Incentive Program. Additionally, all Eligible Professionals included in the group practice who register for the Wisconsin Medicaid EHR Incentive Program must also register using the group practice patient volume.

A group practice is defined by how a group practice enumerates its business using NPIs (National Provider Identifiers). When calculating a group practice patient volume, the group practice patient volume methodology can only be used if all of the following conditions are satisfied:

- The eligible members included in the group practice patient volume calculation were provided services during the 90-day period that the group practice is attesting (for the first year).
- There is an auditable data source to support a group practice's patient volume determination.
- All Eligible Professionals in the group practice use the same methodology for the payment year.
- The group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way.
- If an Eligible Professional works inside and outside the group practice, the patient volume calculation may only include those encounters associated with the group practice and not individual encounters outside the group practice.

Note: Eligible Professionals should note that whether they calculate their eligible member patient encounter volume as a group practice or as an individual will not affect how the incentive payments are distributed. For example, an Eligible Professional may calculate their eligible member patient volume at an individual level and assign payment to their group practice. Conversely, an Eligible Professional may calculate their eligible member patient volume at a group practice level and assign payment to themselves.

Eligible Professionals calculating group practice patient volume under the eligible member patient volume must meet a minimum of at least 30 percent of their patient volume attributed to eligible members. The standard deduction must be applied to the total (in-state) eligible member-only patient encounters of the group and rounded to the nearest whole number prior to entry in the Wisconsin EHR Incentive Program application.

Topic #12101

Example of Calculating Group Practice Patient Volume

Eligible Professionals must have at least 30 percent of their patient volume encounters attributed to eligible members. When electing to use group practice patient volume, the entire practice's patient volume must be included. This includes the services rendered by all Eligible Professionals within the group practice, regardless of provider type or eligibility status for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. Groups are defined by how their businesses are enumerated under their NPI (National Provider Identifier).

The following is an example of calculating group practice volume for the purpose of establishing eligibility for the Wisconsin Medicaid EHR Incentive Program.

Eligible Based on Provider Type	Provider Type	Total Encounters (Eligible Members/Total)	Percentage of Eligible Member Encounters
Yes	Physician	80/200	40 percent
Yes	Nurse Practitioner	50/100	50 percent
Yes	Physician	0/100	0 percent
No	Registered Nurse	150/200	75 percent
No	Pharmacist	80/100	80 percent
Yes	Physician	30/300	10 percent

Yes	Dentist	5/100	5 percent
Yes	Dentist	60/200	30 percent

In this scenario, there are 1300 encounters in the selected 90-day period. Of the 1300 encounters, 455 are attributable to eligible members, or 35 percent. The next step is to apply the standard deduction ($1 - .0801 = 0.9199$) to the number of eligible members.

$$455 * 0.9199 = 418.554$$

That number is divided by the total number of encounters in the selected 90-day period, or 1300.

$$418.554 / 1300 = 0.321 \text{ or } 32.1 \text{ percent}$$

Therefore, the group practice patient volume is 32.1 percent, which is rounded to the nearest whole number of 32 percent, and is eligible for the Wisconsin Medicaid EHR Incentive Program.

Eligible Professionals should note that even though one dentist's eligible member encounter percentage was only 5 percent and one physician's eligible member encounter percentage was 10 percent, when included in the group practice patient volume, both are eligible for the program when registering with the group practice patient volume. The physician whose eligible member encounter percentage is zero is not eligible for the program because he or she did not render services to at least one eligible member.

Topic #12100

Example of Calculating Individual Patient Volume

Eligible Professionals must have at least 30 percent (except pediatricians, who must have at least 20 percent) of their patient volume attributed to eligible members. For example, if an Eligible Professional calculates his or her total eligible member patient encounter volume of 33 out of a total patient encounter volume of 75, the eligible member patient volume is 44 percent.

Eligible Professionals may be unable to distinguish between some eligible members and some non-eligible members when determining their patient volume. The Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program only considers services provided to members who are reimbursed with funding directly from Medicaid (Title XIX) as a patient encounter. Eligible Professionals may be unable to determine where funding for eligible members comes from, so in order to assist Eligible Professionals in determining their eligible patient encounters, the Wisconsin Medicaid EHR Incentive Program will calculate a standard deduction. The standard deduction for 2013 is 8.01 percent.

To figure out the eligible member patient encounters, Eligible Professionals must multiply their total eligible member encounter patient volume by a factor of $(1 - .0801)$ or 0.9199 and then divide that number by their total eligible member patient encounter volume.

Standard Deduction Calculation

Total eligible member patient encounters during any 90-day continuous period * 0.9199

----- * 100

Total patient encounters, regardless of payer over that same 90-day continuous period

-Or-

$$33 * 0.9199$$

----- * 100 = 40.47 percent

75

So the final eligible member patient encounter volume is 30.35 encounters out of 75 total, or 40.47 percent, rounded to the nearest whole number, 40 percent.

Therefore, 40 percent of the Eligible Professional's patient volume is eligible members and the Eligible Professional fulfills the patient volume requirement for the Wisconsin Medicaid EHR Incentive Program. Eligible Professionals should note that the Wisconsin Medicaid EHR Incentive Program will not round up to meet the minimum patient volume threshold. All patient volumes reported that are below 30 percent (including those at or below 29.99 percent) will be deemed ineligible.

Topic #12097

Members Who May Be Counted When Determining Patient Volume

Most members enrolled in the programs listed below are considered eligible members and may be counted when determining patient encounters and patient volume:

- Wisconsin Medicaid.
- BadgerCare Plus Standard Plan.
- BadgerCare Plus Benchmark Plan.
- BadgerCare Plus Core Plan.
- BadgerCare Plus Express Enrollment for Pregnant Women.
- Alien Emergency Service Only.
- TB-Only (Tuberculosis-Related Service Only) Benefit.
- Family Planning Only Services.

Note: There are certain members enrolled in these programs or certain services provided to eligible members that may be included in the patient volume, which is the reason for the standard deduction.

Topic #12099

Needy Individual Patient Volume

The federal law stipulates that only certain services rendered to certain individuals may be counted towards the needy individual patient volume requirements. The Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program defines needy individuals as those listed [here](#) as well as those who are provided uncompensated care by the provider, or individuals provided services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

Only Eligible Professionals, including pediatricians, practicing predominantly in an FQHC (Federally Qualified Health Center) or RHC (Rural Health Clinic) may use the Needy Individual Patient Volume method. An Eligible Professional is defined as practicing predominantly in a FQHC or RHC if more than 50 percent of the Eligible Professional's encounters occur in an FQHC or RHC during a six-month period in the most recent calendar year or in the most recent 12 months prior to attestation.

Eligible Professionals using the Needy Individual Patient Volume method must meet a minimum of 30 percent needy individual patient volume threshold. Needy Individual Patient Volume encounters consist of the following:

- Services rendered on any one day to an individual where Medicaid or BadgerCare Plus paid all or part of the service including copayments or any other cost-sharing.
- Services rendered on any one day to an individual where Children's Health Insurance Program under Title XXI paid for part or all of the service.
- Services rendered on any one day to an individual furnished by the provider as uncompensated care.
- Services rendered on any one day to an individual furnished at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

Eligible Professionals using the Needy Individual Patient Volume method may elect to calculate patient volume at an individual or a group practice level. If an Eligible Professional calculates his or her patient encounter volume based on a group practice, the entire group practice's patient volume must be included. This includes the services rendered by all providers within the group practice, regardless of provider type or eligibility status for the Wisconsin Medicaid EHR Incentive Program. Additionally, all Eligible Professionals included in the group practice who register for the Wisconsin Medicaid EHR Incentive Program must also register using the group practice patient volume.

A group practice is defined by how a group practice enumerates its business using NPIs (National Provider Identifiers). When calculating a group practice patient volume, the group practice patient volume methodology can only be used if all of the following conditions are satisfied:

- The eligible members included in the group practice patient volume calculation were provided services during the 90-day period that the organization is attesting (for the first year).
- There is an auditable data source to support a group practice's patient volume determination.
- All Eligible Professionals in the group practice use the same methodology for the payment year.
- The group practice uses the entire group practice's patient volume and does not limit patient volume in any way.
- If an Eligible Professional works inside and outside the group practice, the patient volume calculation may only include those encounters associated with the group practice and not individual encounters outside the group practice.

Note: Eligible Professionals should note that whether they calculate their needy individual patient encounter volume as a group practice or as an individual will not affect how the incentive payments are distributed. For example, an Eligible Professional may calculate his or her needy individual patient volume at an individual level and assign payment to the group practice. Conversely, an Eligible Professional may calculate his or her needy individual patient volume at a group practice level and assign payment to him- or herself.

Eligible Professionals calculating group patient volume under the needy individual patient volume must meet a minimum of at least 30 percent of their patient volume attributed to needy individuals. The standard deduction must be applied to the total (in-state) eligible member-only patient encounters of the organization and rounded to the nearest whole number prior to entry in the Wisconsin EHR Incentive Program application.

Topic #12078

Patient Volume Requirements and Calculations

In addition to other EHR (Electronic Health Record) Incentive Program requirements, Eligible Professionals must meet patient volume thresholds over the course of a 90-day period.

Eligible Professionals are required to select one of the following patient volume reporting periods:

- Calendar year preceding payment year.
- Twelve months preceding attestation date.

Note: The attestation date is defined as the day when the application is electronically signed and submitted for the first time in the Program Year or the last day of the Program Year if applying during the grace period.

An Eligible Professional cannot calculate patient volume by including patient encounters that occur during the 90-day grace period following the Program Year. For example, an Eligible Professional who applies for Program Year 2013 participation cannot include patient encounters occurring after December 31, 2013.

An Eligible Professional cannot use the same or overlapping patient volume periods for future Program Year applications. For example, an Eligible Professional uses January 1, 2013, through March 31, 2013, for Program Year 2013. In Program Year 2014, the Eligible Professional cannot use January 1, 2013, through March 31, 2013, or any overlapping period (i.e., February 1, 2013, through April 30, 2013).

When reporting patient volume, Eligible Professionals will designate which practice locations are using certified EHR technology and enter the relevant patient encounter data needed to determine eligibility. Patient encounter data will be entered in three parts for each practice location:

- The total (in-state) eligible member-only patient encounter volume over the previously determined continuous 90-day reporting period.
- The total (regardless of state) eligible member-only patient encounter volume over the previously determined continuous 90-day reporting period.
- The total patient encounter volume (regardless of state or payer) over the previously determined continuous 90-day reporting period.

When attesting to Wisconsin Medicaid EHR Incentive Program patient volume requirements, there are two methods by which an Eligible Professional may calculate patient volume.

- Eligible member patient volume.
- Needy individual patient volume.

Each patient volume method contains its own unique requirements; however, only Eligible Professionals practicing in an FQHC (federally qualified health center) or RHC (rural health clinic) may use the needy individual patient volume method.

Registration and Applying

Topic #12057

Individuals Applying for the EHR Incentive Program

A secure Provider account on the ForwardHealth Portal is required to apply for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. All applications must be completed via a secure Provider Portal account.

An Eligible Professional applying as an individual needs to follow the process below when applying for the Wisconsin Medicaid EHR Incentive Program:

- The Eligible Professional needs to first log in to the Portal. If the Eligible Professional does not have a Portal account, he or she needs to obtain one. The Eligible Professional should refer to the Account User Guide on the [Portal User Guides page](#) of the Provider area of the Portal for more information on obtaining a Portal account.
- The Eligible Professional needs to click on the Wisconsin Medicaid EHR Incentive Program link in the Quick Link box.
- The Eligible Professional will have to designate payment to either him- or herself or to the organization.

Topic #12040

Organizations Applying for the EHR Incentive Program on Behalf of Eligible Professionals

A secure Provider Portal account is required to apply for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. All applications must be completed via a secure Provider ForwardHealth Portal account.

Organizations applying on behalf of Eligible Professionals need to follow the process below when applying for the Wisconsin Medicaid EHR Incentive Program:

- The organization needs to first log in to the Portal. The organization only needs one Portal account to apply for all Eligible Professionals assigning payment to their organization and associated with the organization's federal TIN (tax identification number). If the organization does not have a Portal account, it needs to obtain one. Refer to the Account User Guide on the [Portal User Guides page](#) of the Provider area of the Portal for more information on obtaining a Portal account.
- Portal Administrators will automatically have access to the Wisconsin Medicaid EHR Incentive Program application. Organizations may assign the new "EHR Incentive" role to a clerk to conduct all Wisconsin Medicaid EHR Incentive Program business.
- The organization may access the EHR Incentive Program application by clicking on the Wisconsin Medicaid EHR Incentive Program link in the Quick Link box.
- The organization will see a list of all Eligible Professionals that are associated with the organization's TIN. The organization will have to submit a separate application for each Eligible Professional associated with their TIN. Organizations should note that once an application has begun for an Eligible Professional, only the Portal account used to begin the application can access that Eligible Professional's application.

Topic #12039

Registration for the EHR Incentive Program with CMS

All Eligible Professionals are required to first register at the [R&A \(Medicare and Medicaid Electronic Health Record Incentive Program Registration and Attestation System\) Web site](#). A step-by-step walkthrough of the R&A registration process for Eligible Professionals is also available [online](#).

After an Eligible Professional successfully registers on the R&A, CMS (Centers for Medicare and Medicaid Services) will process the registration and send the file to the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. After receipt of the file, the Wisconsin Medicaid EHR Incentive Program will enter all relevant information into the ForwardHealth system. Eligible Professionals must wait two full business days before beginning the application for the Wisconsin Medicaid EHR Incentive Program to allow for this process.

Topic #12058

Required Information When Starting the EHR Incentive Program Application

Eligible Professionals will be required to supply specific information when completing the EHR (Electronic Health Record) Incentive Program application. Eligible Professionals do not have to complete the entire application in one session. The application will allow users to save the information entered and return later to complete the application.

Eligible Professionals should have the following information available when beginning the application:

- Information submitted to the R&A (Medicare and Medicaid Electronic Health Record Incentive Program Registration and Attestation System). Eligible Professionals will need to confirm all of this information during the initial application phases.
- Contact name, telephone number, and e-mail address of the authorized preparer of the Eligible Professional's application, if not the Eligible Professional.
- Information regarding whether or not the Eligible Professional applying to the Wisconsin Medicaid EHR Incentive Program has any sanctions or pending sanctions with the Medicare or Medicaid programs and is licensed to practice in all states in which services are rendered.
- The CMS (Centers for Medicare and Medicaid Services) EHR certification ID for the certified EHR technology the Eligible Professional already has or is contractually obligated to acquire. For more information on approved EHR technology, Eligible Professionals should refer to the ONC (Office of the National Coordinator for Health Information Technology)-certified EHR [product list](#).
- Required Patient Volume Data:
 - The total in-state eligible member patient encounter volume over the previously determined continuous 90-day reporting period.
 - The total eligible member patient encounter volume over the previously determined continuous 90-day reporting period.
 - The total patient encounter volume over the previously determined continuous 90-day reporting period.

Topic #12077

Reviewing, Confirming, and Submitting the EHR Incentive Program Application

After completing attestations for the EHR (Electronic Health Record) Incentive Program, the Eligible Professional will be asked to review all answers provided. An error-checking function will identify any errors found in the application.

Final submission will require an electronic signature by providing the preparer or the Eligible Professional's initials, the Eligible Professional's NPI (National Provider Identifier) and the Eligible Professional's personal TIN (tax identification number). If

completed through the use of an authorized preparer, that preparer will also need to include his or her name and relationship to the Eligible Professional and then electronically sign the application before submission. Once the Wisconsin Medicaid EHR Incentive Program application has been completed and submitted, an e-mail notification will be sent to confirm the application's submission. After an application is successfully submitted and approved, Eligible Professionals can expect payments within 45 days.

Resources for EHR Incentive Program

Topic #12138

Provider Services

Eligible Professionals and Eligible Hospitals should call [Provider Services](#) with all questions regarding the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program.

Topic #12139

User Guide

Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program User Guides for Eligible Professionals and Eligible Hospitals are available on the [Portal User Guides page](#) of the Provider area of the ForwardHealth Portal.

Topic #12140

Web Sites

The following Web sites provide additional information regarding the EHR (Electronic Health Record) Incentive Program.

Available Resources	Web Sites
Wisconsin Medicaid EHR Incentive Program Web Site	www.dhs.wisconsin.gov/ehrincentive/
CMS (Centers for Medicare and Medicaid Services) EHR Incentive Program	https://www.cms.gov/EHRIncentivePrograms/
Wisconsin Health Information Technology Extension Center Web Site	www.whitec.org/

Managed Care

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Archive Date:01/02/2014

Managed Care:Claims

Topic #385

Appeals to BadgerCare Plus and Wisconsin Medicaid

The provider has 60 calendar days to file an appeal with BadgerCare Plus or Wisconsin Medicaid after the HMO (health maintenance organization) or SSI (Supplemental Security Income) HMO either does not respond in writing within 45 calendar days or if the provider is dissatisfied with the HMO's or SSI HMO's response.

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

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

Appeals must be made in writing and must include:

- A letter, clearly marked "APPEAL," explaining why the claim should be paid or a completed [Managed Care Program Provider Appeal \(F-12022 \(03/09\)\)](#) form.
- A copy of the claim, clearly marked "APPEAL."
- A copy of the provider's letter to the HMO or SSI HMO.
- A copy of the HMO's or SSI HMO's response to the provider.
- Any documentation that supports the case.

The appeal will be reviewed and any additional information needed will be requested from the provider or the HMO or SSI HMO. Once all pertinent information is received, BadgerCare Plus or Wisconsin Medicaid has 45 calendar days to make a final decision.

The provider and the HMO or SSI HMO will be notified in writing of the final decision. If the decision is in favor of the provider, the HMO or SSI HMO is required to pay the provider within 45 calendar days of the final decision. The decision is final, and all parties must abide by the decision.

Topic #384

Appeals to HMOs and SSI HMOs

Providers are required to first file an appeal directly with the BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO within 60 calendar days of receipt of the initial denial. Providers are required to include a letter explaining why the HMO or SSI HMO should pay the claim. The appeal should be sent to the address indicated on the HMO's or SSI HMO's denial notice.

The HMO or SSI HMO then has 45 calendar days to respond in writing to the appeal. The HMO or SSI HMO decides whether to pay the claim and sends the provider a letter stating the decision.

If the HMO or SSI HMO does not respond in writing within 45 calendar days, or if the provider is dissatisfied with the HMO's or SSI HMO's response, the provider may send a written appeal to ForwardHealth within 60 calendar days.

Topic #386

Claims Submission

BadgerCare Plus HMOs (health maintenance organizations) and Medicaid SSI (Supplemental Security Income) HMOs have requirements for timely filing of claims, and providers are required to follow HMO and SSI HMO claims submission guidelines. Contact the enrollee's HMO or SSI HMO for organization-specific submission deadlines.

Topic #387

Extraordinary Claims

Extraordinary claims are BadgerCare Plus or Medicaid claims for a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO enrollee that have been denied by an HMO or SSI HMO but may be paid as fee-for-service claims.

The following are some examples of extraordinary claims situations:

- The enrollee was not enrolled in an HMO or SSI HMO at the time he or she was admitted to an inpatient hospital, but then enrolled in an HMO or SSI HMO during the hospital stay. In this case, all claims related to the stay (including physician claims) should be submitted to fee-for-service. For the physician claims associated with the inpatient hospital stay, the provider is required to include the date of admittance and date of discharge in Element 18 of the paper 1500 Health Insurance Claim Form.
- The claims are for orthodontia/prostodontia services that began before HMO or SSI HMO coverage. Include a record with the claim of when the bands were placed.

Submitting Extraordinary Claims

When submitting an extraordinary claim, include the following:

- A legible copy of the completed claim form, in accordance with billing guidelines.
- A letter detailing the problem, any claim denials, and any steps taken to correct the situation.

Submit extraordinary claims to:

ForwardHealth
Managed Care Extraordinary Claims
PO Box 6470
Madison WI 53716-0470

Topic #388

Medicaid as Payer of Last Resort

Wisconsin Medicaid is the payer of last resort for most covered services, even when a member is enrolled in a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO. Before submitting claims to HMOs and SSI HMOs, providers are required to submit claims to other health insurance sources. Contact the enrollee's HMO or SSI HMO for more information about billing other health insurance sources.

Topic #389

Provider Appeals

When a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO denies a provider's claim, the HMO or SSI HMO is required to send the provider a notice informing him or her of the right to file an appeal.

An HMO or SSI HMO network or non-network provider may file an appeal to the HMO or SSI HMO when:

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

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

Covered and Noncovered Services

Topic #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:

- 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:

- Community Support Program.
- Comprehensive Community Services.
- Crisis intervention services.
- SBS.
- Targeted case management services.

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

Topic #390

Covered Services

HMOs

HMOs (health maintenance organizations) are required to provide at least the same benefits as those provided under fee-for-service arrangements. Although ForwardHealth requires contracted HMOs and Medicaid SSI (Supplemental Security Income) HMOs to provide all medically necessary covered services, the following services may be provided by BadgerCare Plus HMOs at their discretion:

- Dental.
- Chiropractic.

If the HMO does not include these services in their benefit package, the enrollee receives the services on a fee-for-service basis.

Topic #391

Noncovered Services

The following are not covered by BadgerCare Plus HMOs (health maintenance organizations) or Medicaid SSI (Supplemental Security Income) HMOs but are provided to enrollees on a fee-for-service basis provided the member's fee-for-service plan covers the service:

- CRS (Community Recovery Services).
- CSP (Community Support Program) benefits.
- Crisis intervention services.
- Environmental lead inspections.
- CCC (child care coordination) services.
- Pharmacy services and diabetic supplies.
- PNCC (prenatal care coordination) services.
- Provider-administered drugs, including all "J" codes, drug-related "Q" codes, and a limited number of related [administration codes](#).
- SBS (school-based services).
- Targeted case management services.
- NEMT (non-emergency medical transportation) services.
- DOT (directly observed therapy) and monitoring for TB-Only (Tuberculosis-Only Related Services).

Topic #13877

Striving to Quit Initiative — First Breath

Background Information

According to the CDC (Centers for Disease Control and Prevention), almost one million individuals in Wisconsin smoke every day. While the smoking rate for adults overall in the state is about 20 percent, the rate is higher — about 33 percent — for BadgerCare Plus members. Wisconsin Medicaid has received a five-year \$9.2 million grant from the CMS (Centers for Medicare and Medicaid Services) to help BadgerCare Plus members enrolled in participating HMOs (health maintenance organizations) to quit smoking through the Striving to Quit initiative. Striving to Quit includes the following separate, evidence-based programs:

- Wisconsin Tobacco Quit Line (i.e., Quit Line), which offers telephone counseling to eligible members who smoke.
- First Breath, which targets eligible pregnant women who smoke by connecting them to trained tobacco cessation counselors for face-to-face tobacco cessation counseling.

First Breath

The First Breath program offers eligible pregnant women who smoke (or who have quit smoking in the last six months) face-to-face tobacco cessation counseling during their prenatal care visits and up to five face-to-face counseling visits plus additional telephone calls for support during the postpartum phase. To participate in the First Breath program, members may be referred to First Breath by their prenatal care provider or may independently call First Breath without a referral at (800) 448-5148. Members who participate in First Breath via Striving to Quit may be eligible to receive financial incentives of up to \$160.00 for participation in treatment and for quitting smoking.

Enrollment Criteria

To be eligible to receive enhanced services from the First Breath program via Striving to Quit, BadgerCare Plus members must meet the following criteria:

- Be enrolled in the BadgerCare Plus Standard Plan or the BadgerCare Plus Benchmark Plan.
- Be a pregnant smoker.
- Express an interest in quitting smoking.
- Be enrolled in one of the following HMOs:
 - Children's Community Health Plan.
 - CommunityConnect HealthPlan.
 - Managed Health Services.
 - MercyCare Health Plans.
 - Molina Health Care.
 - Network Health Plan.
 - Physicians Plus Insurance Corporation.
 - Unity Health Plans Insurance Corporation.
- Reside in one of the following counties:
 - Dane.
 - Kenosha.
 - Milwaukee.
 - Racine.
 - Rock.

Covered Services

The following services are covered by Striving to Quit via First Breath:

- Up to 10 one-on-one counseling sessions during regular prenatal care appointments by First Breath providers.
- Five one-on-one counseling sessions with a trained First Breath Health Educator following delivery.
- Up to six telephone calls with the First Breath Health Educator following delivery.

Provider Responsibilities

Providers are responsible for screening pregnant BadgerCare Plus HMO members for smoking and enrolling them in the First Breath program or referring members to the First Breath program.

Clinics that currently provide First Breath services are responsible for the following:

- Screening for smoking and enrolling members in First Breath.
- Encouraging members to enroll in Striving to Quit.
- Providing regular First Breath counseling during prenatal care visits.
- Completing First Breath data forms and submitting the forms via fax to (608) 251-4136 or mail to the following address:

Wisconsin Women's Health Foundation
2503 Todd Dr
Madison WI 53713

Clinics that do not currently provide First Breath smoking cessation services should refer members to First Breath.

Screening and Making Referrals

For clinics that currently provide First Breath services, there are no changes to current procedures.

The following language is suggested for providers to use to encourage members to enroll in First Breath:

One of the benefits of enrolling in First Breath now is that you may be eligible to participate in a stop smoking study that provides free counseling services to help you quit and will pay you for taking part in certain activities. You can learn more about the program when someone from the First Breath office calls you or when you call them.

Clinics that do not currently provide First Breath services should encourage pregnant BadgerCare Plus members to seek help to quit by using the above language. Clinic staff or the member may call the First Breath program at (800) 448-5148, extension 112, for help in finding a First Breath provider in the member's area. Members may also visit the [First Breath Web site](#) to locate a First Breath provider.

Becoming a First Breath Site

Clinics not currently providing First Breath services may become First Breath sites by calling the First Breath Coordinator at (800) 448-5148, extension 112, or by visiting the First Breath Web site. Providers will need to complete four hours of training to provide First Breath services. Training is free and provided by First Breath coordinators on site. Becoming a First Breath site allows all pregnant BadgerCare Plus and Medicaid members to be served during their regular prenatal care visits.

After becoming a First Breath site, clinics will need to do the following:

- Provide evidence-based cessation counseling during regular prenatal care.
- Complete enrollment and other data forms.
- Distribute small, non-cash gifts supplied by the First Breath program.

For More Information

For more information about Striving to Quit, providers should contact their HMO representative, visit the ForwardHealth Portal, or e-mail Striving to Quit at dhsstqinfo@wisconsin.gov.

For more information or for technical assistance questions regarding the Quit Line, providers may visit the [UW-CTRI \(University of Wisconsin Center for Tobacco Research and Intervention\) Web site](#).

For more information or for technical assistance questions regarding First Breath, providers may call First Breath at (800) 448-5148, extension 112, or visit the First Breath Web site.

Topic #13857

Striving to Quit Initiative — Wisconsin Tobacco Quit Line

Background Information

According to the CDC (Centers for Disease Control and Prevention), almost one million individuals in Wisconsin smoke every day. While the smoking rate for adults overall in the state is about 20 percent, the rate is higher — about 33 percent — for BadgerCare Plus members. Wisconsin Medicaid has received a five-year \$9.2 million grant from the CMS (Centers for Medicare and Medicaid Services) to help BadgerCare Plus members enrolled in participating HMOs (health maintenance organizations) to quit smoking through the Striving to Quit initiative. Striving to Quit includes the following separate, evidence-based programs:

- Wisconsin Tobacco Quit Line (i.e., Quit Line), which offers telephone counseling to eligible members who smoke.
- First Breath, which targets eligible pregnant women who smoke by connecting them to trained tobacco cessation counselors for face-to-face tobacco cessation counseling.

Wisconsin Tobacco Quit Line

Striving to Quit offers eligible members who smoke enhanced tobacco cessation treatment from the Quit Line. Members who participate in Striving to Quit qualify for at least five smoking cessation counseling calls from the Quit Line and appropriate tobacco cessation medications covered by Wisconsin Medicaid. To participate in Striving to Quit, members may be referred to the Quit Line by their provider or may independently call the Quit Line without a referral at (800) QUIT-NOW (784-8669).

Striving to Quit members using the Quit Line may be eligible to receive financial incentives of up to \$120.00 for participation in treatment and for quitting smoking. Striving to Quit requires members who participate in Quit Line treatment services to take a biochemical test to confirm smoking status at initial enrollment, six months post-enrollment, and 12 months after enrollment in the initiative.

Enrollment Criteria

To be eligible to receive enhanced services from the Quit Line via Striving to Quit, members must meet the following criteria:

- Be enrolled in BadgerCare Plus Standard Plan or BadgerCare Plus Benchmark Plan.
- Be 18 years of age and older.
- Be a smoker and express an interest in quitting smoking.
- Be enrolled in one of the following HMOs:
 - Children's Community Health Plan.
 - Compcare.
 - Group Health Cooperative of Eau Claire.
 - Managed Health Services.
 - MercyCare Health Plans.
 - Molina Health Care.
 - Network Health Plan.
 - Physicians Plus Insurance Corporation.
 - UnitedHealthcare Community Plan.
 - Unity Health Plans Insurance Corporation.
 - Reside in one of the following counties:
 - Brown.
 - Calumet.
 - Columbia.
 - Dane.
 - Dodge.
 - Door.
 - Florence.
 - Fond du Lac.
 - Grant.

- Green.
- Iowa.
- Jefferson.
- Kewaunee.
- Lafayette.
- Manitowoc.
- Marinette.
- Menominee.
- Oconto.
- Outagamie.
- Rock.
- Sauk.
- Sheboygan.
- Walworth.
- Waupaca.
- Winnebago.

Covered Drugs and Services

The following drugs and services are covered by Striving to Quit or Medicaid:

- Up to five cessation counseling calls to the Quit Line plus additional calls initiated by the member are covered by Striving to Quit.
- Tobacco cessation medications and biochemical testing to confirm smoking status are covered by Medicaid.

Provider Responsibilities

For members seeking Striving to Quit services from the Quit Line, providers are responsible for the following:

- Screening for smoking and referring potentially eligible members who smoke to the Quit Line.
- Conducting biochemical tests (i.e., urine cotinine tests).
- Writing prescriptions for tobacco cessation drugs for members, as appropriate.
- Working with the Quit Line, completing Striving to Quit referral forms for member referrals, writing tobacco cessation prescriptions, and faxing biochemical test results and forms to the Quit Line.
- Identifying one or two key staff members in a clinic or practice who will serve as points of contact for Striving to Quit and assist with coordinating the biochemical tests and other tasks as needed.

Screening and Making Referrals

The following language is suggested for providers to use to encourage members who smoke to agree to a referral or to call the Quit Line themselves:

One of the benefits of calling the Quit Line now is that you may be eligible to participate in a stop smoking study that provides free counseling services to help you quit and will pay you for taking part in certain activities. I would be happy to make a referral for you. If you are interested, all we need to do is a simple urine test to confirm that you smoke. After I send the paperwork, someone from the Quit Line will call you to tell you more about the study or you can call them directly at the number on the card. If you do not want to be in the study, you may still get some services from the Quit Line.

Providers should ask HMO members living in targeted counties if they may refer the member to the Quit Line. If a member is referred to the Quit Line, providers should submit a Striving to Quit Referral form signed by the member to the Quit Line via fax at (877) 554-6643. Striving to Quit Referral forms are available on the [UW-CTRI's \(University of Wisconsin Center for Tobacco](#)

[Research and Intervention\) Striving to Quit Web site](#) or on the ForwardHealth Portal. A representative from the Quit Line will call the member within three business days to begin the enrollment process.

Outreach Specialists for the UW-CTRI will provide technical assistance to clinics and providers about how to make Striving to Quit referrals. A short training video about Striving to Quit procedures is available on UW-CTRI's Web site. A link to the training video is also on the Portal.

Biochemical Testing

As part of Striving to Quit, HMO members are required to have a urine cotinine test to confirm smoking status. This test should be conducted by providers in the member's HMO network using NicCheck[®] I testing strips. NicCheck[®] I testing strips (item MA-500-001) may be [ordered online](#) or by calling (888) 882-7739.

Urine cotinine test results should be faxed to the Quit Line at (877) 554-6643. Claims for urine cotinine testing should be submitted to the member's HMO.

BadgerCare Plus members may be tested on a walk-in basis at any participating clinic in the member's HMO network. Members who need assistance finding a participating clinic should contact their HMO.

Prescriptions

For HMO members identified as smokers who express an interest in quitting and agree to a referral to the Quit Line, providers should discuss the use of tobacco cessation medications. Research indicates that the use of tobacco cessation medications in combination with evidence-based counseling almost doubles the likelihood of a successful quit attempt. The following types of tobacco cessation medications are covered by Wisconsin Medicaid for BadgerCare Plus members:

- OTC (over-the-counter) nicotine gum and patches.
- Legend products (i.e., bupropion SR, Chantix, Nicotrol spray).

Providers may use the [Drug Search Tool](#) to determine the most current covered drugs. Providers may also refer to the [benefit plan-specific product lists](#) for the most current list of covered drugs.

An [allowable diagnosis code](#) must be indicated on claims for covered tobacco cessation medications. Tobacco cessation medications are not covered for uses outside the allowable diagnosis code.

If tobacco cessation medications are appropriate for members, prescriptions for tobacco cessation medications should be sent to the member's pharmacy. On the Striving to Quit Referral form sent to the Quit Line, the tobacco cessation medication prescription box should be checked either yes or no.

For HMO members who independently call the Quit Line and are enrolled in Striving to Quit, staff at the Quit Line will provide a suggested prescription to a provider within the member's HMO network. The provider will determine the adequacy of the prescription and approve as appropriate. The provider is required to send the following:

- The prescription to the pharmacy where it will be filled (e-prescribing is preferred).
- The approval or disapproval of the prescription to the Quit Line on the Striving to Quit Referral form via fax at (877) 554-6643.

For More Information

For more information about Striving to Quit, providers should contact their HMO representative, visit the Portal, or e-mail Striving to Quit at dhsstqinfo@wisconsin.gov.

For more information or for technical assistance questions regarding the Quit Line, providers may visit the [UW-CTRI \(University of Wisconsin Center for Tobacco Research and Intervention\) Web site](#).

Enrollment

Topic #392

Disenrollment and Exemptions

In some situations, a member may be exempt from enrolling in a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO. Exempted members receive health care under fee-for-service. Exemptions allow members to complete a course of treatment with a provider who is not contracted with the member's HMO or SSI HMO. For example, in certain circumstances, women in high-risk pregnancies or women who are in the third trimester of pregnancy when they are enrolled in an HMO or SSI HMO *may* qualify for an exemption.

The [contracts](#) between the DHS (Department of Health Services) and the HMO or SSI HMO provide more detail on the exemption and disenrollment requirements.

Topic #393

Enrollee Grievances

Enrollees have the right to file grievances about services or benefits provided by a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO. Enrollees also have the right to file a grievance when the HMO or SSI HMO refuses to provide a service. All HMOs and SSI HMOs are required to have written policies and procedures in place to handle enrollee grievances. Enrollees should be encouraged to work with their HMO's or SSI HMO's customer service department to resolve problems first.

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

The [contracts](#) between the DHS (Department of Health Services) and the HMO or SSI HMO describes the responsibilities of the HMO or SSI HMO and the DHS regarding enrollee grievances.

Topic #397

Enrollment Eligibility

BadgerCare Plus HMOs

Members enrolled in the BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, and the BadgerCare Plus Core Plan are eligible for enrollment in a BadgerCare Plus HMO (health maintenance organization).

An individual who receives the TB-Only (Tuberculosis-Related Services-Only) benefit, SeniorCare, or Wisconsin Well Woman Medicaid cannot be enrolled in a BadgerCare Plus HMO.

Information about a member's HMO enrollment status and commercial health insurance coverage may be verified by using Wisconsin's [EVS \(Enrollment Verification System\)](#) or the ForwardHealth Portal.

SSI HMOs

Members of the following subprograms are eligible for enrollment in a Medicaid SSI (Supplemental Security Income) HMO:

- Individuals ages 19 and older, who meet the SSI and SSI-related disability criteria.
- Dual eligibles for Medicare and Medicaid.

Individuals who are living in an institution, nursing home, or participating in a Home and Community-Based Waiver program are not eligible to enroll in an SSI MCO (managed care organization).

Topic #394

Enrollment Periods

HMOs

Members are sent enrollment packets that explain the BadgerCare Plus HMOs (health maintenance organizations) and the enrollment process and provide contact information. Once enrolled, enrollees may change their HMO assignment within the first 90 days of enrollment in an HMO (whether they chose the HMO or were auto-assigned). If an enrollee no longer meets the criteria, he or she will be disenrolled from the HMO.

SSI HMOs

Members are sent enrollment packets that explain the Medicaid SSI (Supplemental Security Income) HMO's enrollment process and provide contact information. Once enrolled, enrollees may disenroll after a 60-day trial period and up to 120 days after enrollment and return to Medicaid fee-for-service if they choose.

Topic #395

Enrollment Specialist

The [Enrollment Specialist](#) provides objective enrollment, education, outreach, and advocacy services to BadgerCare Plus HMO (health maintenance organization) and Medicaid SSI (Supplemental Security Income) HMO enrollees. The Enrollment Specialist is a knowledgeable single point of contact for enrollees, solely dedicated to managed care issues. The Enrollment Specialist is not affiliated with any health care agency.

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

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

Topic #398

Member Enrollment

HMOs

BadgerCare Plus HMO (health maintenance organization) enrollment is either mandatory or voluntary based on ZIP code-defined enrollment areas as follows:

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

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

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

SSI HMOs

Medicaid SSI (Supplemental Security Income) HMO enrollment is either mandatory or voluntary as follows:

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

Topic #396

Ombudsman Program

The [Ombudsmen](#), or Ombuds, are resources for enrollees who have questions or concerns about their BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO. Ombuds provide advocacy and assistance to help enrollees understand their rights and responsibilities in the grievance and appeal process.

Ombuds can be contacted at the following address:

BadgerCare Plus HMO/Medicaid SSI HMO Ombudsmen
PO Box 6470
Madison WI 53716-0470

Topic #399

Release of Billing or Medical Information

ForwardHealth supports BadgerCare Plus HMO (health maintenance organization) and Medicaid SSI (Supplemental Security Income) HMO enrollee rights regarding the confidentiality of health care records. ForwardHealth has [specific standards](#) regarding the release of an HMO or SSI HMO enrollee's billing information or medical claim records.

Managed Care Information

Topic #401

BadgerCare Plus HMO Program

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

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

Topic #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 and claim submission guidelines, if they are already a Care4Kids network provider.

Topic #405

Managed Care

Managed Care refers to the BadgerCare Plus HMO (health maintenance organization) program, the Medicaid SSI (Supplemental Security Income) HMO program, and the several special managed care programs available.

The primary goals of the managed care programs are:

- To improve the quality of member care by providing continuity of care and improved access.
- To reduce the cost of health care through better care management.

Topic #402

Managed Care Contracts

The contract between the DHS (Department of Health Services) and the BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO takes precedence over other ForwardHealth provider publications. Information contained in ForwardHealth publications is used by the DHS to resolve disputes regarding covered benefits that cannot be handled internally by HMOs and SSI HMOs. If there is a conflict, the HMO or SSI HMO contract prevails. If the contract does not specifically address a situation, Wisconsin Administrative Code ultimately prevails. HMO and SSI HMO contracts can be found on the Managed Care Organization area of the ForwardHealth Portal.

Topic #404

SSI HMO Program

Medicaid SSI (Supplemental Security Income) HMOs (health maintenance organizations) provide the same benefits as Medicaid fee-for-service (e.g. medical, dental, mental health/substance abuse, vision, and prescription drug coverage) at no cost to their enrollees through a care management model. Medicaid members and SSI-related Medicaid members in certain counties may be eligible to enroll in an SSI HMO.

SSI-related Medicaid members receive coverage from Wisconsin Medicaid because of a disability determined by the Disability Determination Bureau.

Member Enrollment

Members who meet the following criteria are eligible to enroll in an SSI HMO:

- Medicaid-eligible individuals living in a service area that has implemented an SSI managed care program.
- Individuals ages 19 and older.
- Individuals who are enrolled in Wisconsin Medicaid and SSI or receive SSI-related Medicaid.

Individuals who are living in an institution or nursing home or are participating in a home and community-based waiver program or FamilyCare are not eligible to enroll in an SSI HMO.

Ozaukee and Washington Counties

Most SSI and SSI-related Medicaid members who reside in Ozaukee and Washington counties are required to choose the HMO in which they wish to enroll. Dual eligibles (members receiving Medicare and Wisconsin Medicaid) are not required to enroll. After a 60-day trial period and up to 120 days after enrollment, enrollees may disenroll and return to Medicaid fee-for-service if they choose.

Southwestern Wisconsin Counties

SSI members and SSI-related Medicaid members who reside in Buffalo, Jackson, La Crosse, Monroe, Trempealeau, and Vernon counties may choose to receive coverage from the HMO or remain in Wisconsin Medicaid fee-for-service.

Continuity of Care

Special provisions are included in the contract for SSI HMOs for continuity of care for SSI members and SSI-related Medicaid members. These provisions include the following:

- Coverage of services provided by the member's current provider for the first 60 days of enrollment in the SSI program or until the first of the month following completion of an assessment and care plan, whichever comes later. The contracted provider should get a referral from the member's HMO after this.
- Honoring a PA (prior authorization) that is currently approved by Wisconsin Medicaid. The PA must be honored for 60 days or until the month following the HMO's completion of the assessment and care plan, whichever comes later.
- Coverage of drugs that an SSI member is currently taking until a prescriber orders different drugs.

Topic #403

Special Managed Care Programs

Wisconsin Medicaid has several special managed care programs that provide services to individuals who are elderly and/or who have disabilities. These members may be eligible to enroll in voluntary regional managed care programs such as Family Care, the PACE (Program of All-Inclusive Care for the Elderly), and the Family Care Partnership Program. Additional information about

these special managed care programs may be obtained from the Managed Care Organization area of the ForwardHealth Portal.

Prior Authorization

Topic #400

Prior Authorization Procedures

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

Provider Information

Topic #406

Copayments

Providers cannot charge Medicaid SSI (Supplemental Security Income) HMO (health maintenance organization) enrollees copayments for covered services except in cases where the Medicaid SSI HMO does not cover services such as dental, chiropractic, and pharmacy. When services are provided through fee-for-service or to members enrolled in a BadgerCare Plus HMO, copayments will apply.

Topic #407

Emergencies

Non-network providers may provide services to BadgerCare Plus HMO (health maintenance organization) and Medicaid SSI (Supplemental Security Income) HMO enrollees in an emergency without authorization or in urgent situations when authorized by the HMO or SSI HMO. The [contract](#) between the DHS (Department of Health Services) and the HMO or SSI HMO defines an emergency situation and includes general payment requirements.

Unless the HMO or SSI HMO has a written agreement with the non-network provider, the HMO or SSI HMO is only liable to the extent fee-for-service would be liable for an emergency situation, as defined in 42 CFR s. 438.114. Billing procedures for emergencies may vary depending on the HMO or SSI HMO. For specific billing instructions, non-network providers should always contact the enrollee's HMO or SSI HMO.

Topic #408

Non-network Providers

Providers who do not have a contract with the enrollee's BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO are referred to as non-network providers. (HMO and SSI HMO network providers agree to payment amounts and billing procedures in a contract with the HMO or SSI HMO.) Non-network providers are required to direct enrollees to HMO or SSI HMO network providers except in the following situations:

- When a non-network provider is treating an HMO or SSI HMO enrollee for an emergency medical condition as defined in the contract between the DHS (Department of Health Services) and the HMO or SSI HMO.
- When the HMO or SSI HMO has authorized (in writing) an out-of-plan referral to a non-network provider.
- When the service is not provided under the HMO's or SSI HMO's contract with the DHS (such as dental, chiropractic, and pharmacy services).

Non-network providers may not serve BadgerCare Plus HMO or Medicaid SSI HMO enrollees as private-pay patients.

Topic #409

Out-of-Area Care

BadgerCare Plus HMOs (health maintenance organizations) and Medicaid SSI (Supplemental Security Income) HMOs may cover medically necessary care provided to enrollees when they travel outside the HMO's or SSI HMO's service area. The HMO or SSI HMO is required to authorize the services before the services are provided, except in cases of [emergency](#). If the HMO or SSI HMO does not authorize the services, the enrollee may be held responsible for the cost of those services.

Topic #410

Provider Participation

Providers interested in participating in a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO or changing HMO or SSI HMO network affiliations should contact the HMO or SSI HMO for more information. Conditions and terms of participation in an HMO or SSI HMO are pursuant to specific contract agreements between HMOs or SSI HMOs and providers. An HMO or SSI HMO has the right to choose whether or not to contract with any provider.

Topic #411

Referrals

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

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

Topic #412

Services Not Provided by HMOs or SSI HMOs

If an enrollee's BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO benefit package does not include a covered service, such as chiropractic or dental services, any Medicaid-enrolled provider may provide the service to the enrollee and submit claims to fee-for-service.

Member Information

6

Archive Date:01/02/2014

Member Information:Birth to 3 Program

Topic #792

Administration and Regulations

In Wisconsin, Birth to 3 services are administered at the local level by county departments of community programs, human service departments, public health agencies, or any other public agency designated or contracted by the county board of supervisors. The DHS (Department of Health Services) monitors, provides technical assistance, and offers other services to county Birth to 3 agencies.

The enabling federal legislation for the Birth to 3 Program is 34 CFR Part 303. The enabling state legislation is [s. 51.44](#), Wis. Stats., and the regulations are found in [DHS 90](#), Wis. Admin. Code.

Providers may contact the appropriate county Birth to 3 agency for more information.

Topic #790

Enrollment Criteria

A child from birth up to (but not including) age 3 is eligible for Birth to 3 services if the child meets one of the following criteria:

- The child has a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.
- The child has at least a 25 percent delay in one or more of the following areas of development:
 - Cognitive development.
 - Physical development, including vision and hearing.
 - Communication skills.
 - Social or emotional development.
 - Adaptive development, which includes self-help skills.
- The child has atypical development affecting his or her overall development, as determined by a qualified team using professionally acceptable procedures and informed clinical opinion.

BadgerCare Plus provides Birth to 3 information because many children enrolled in the Birth to 3 Program are also BadgerCare Plus members.

Topic #791

Individualized Family Service Plan

A Birth to 3 member receives an IFSP (Individualized Family Service Plan) developed by an interdisciplinary team that includes the child's family. The IFSP provides a description of the outcomes, strategies, supports, services appropriate to meet the needs of the child and family, and the natural environment settings where services will be provided. All Birth to 3 services must be identified in the child's IFSP.

Topic #788

Requirements for Providers

Title 34 CFR Part 303 for Birth to 3 services requires all health, social service, education, and tribal programs receiving federal funds, including Medicaid providers, to do the following:

- Identify children who may be eligible for Birth to 3 services. These children must be referred to the appropriate county Birth to 3 program within *two working days* of identification. This includes children with developmental delays, atypical development, disabilities, and children who are substantiated as abused or neglected. For example, if a provider's health exam or developmental screen indicates that a child may have a qualifying disability or developmental delay, the child must be referred to the county Birth to 3 program for evaluation. (Providers are encouraged to explain the need for the Birth to 3 referral to the child's parents or guardians.)
- Cooperate and participate with Birth to 3 service coordination as indicated in the child's IFSP (Individualized Family Services Plan). Birth to 3 services must be provided by providers who are employed by, or under agreement with, a Birth to 3 agency to provide Birth to 3 services.
- Deliver Birth to 3 services in the child's natural environment, unless otherwise specified in the IFSP. The child's natural environment includes the child's home and other community settings where children without disabilities participate. (Hospitals contracting with a county to provide therapy services in the child's natural environment must receive separate enrollment as a therapy group to be reimbursed for these therapy services.)
- Assist parents or guardians of children receiving Birth to 3 services to maximize their child's development and participate fully in implementation of their child's IFSP. For example, an occupational therapist is required to work closely with the child's parents and caretakers to show them how to perform daily tasks in ways that maximize the child's potential for development.

Topic #789

Services

The Birth to 3 Program covers the following types of services when they are included in the child's IFSP (Individualized Family Services Plan):

- Evaluation and assessment.
- Special instruction.
- OT (occupational therapy).
- PT (physical therapy).
- SLP (speech and language pathology).
- Audiology.
- Psychology.
- Social work.
- Assistive technology.
- Transportation.
- Service coordination.
- Certain medical services for diagnosis and evaluation purposes.
- Certain health services to enable the child to benefit from early intervention services.
- Family training, counseling, and home visits.

Enrollment Categories

Topic #785

BadgerCare Expansion for Certain Pregnant Women

As a result of 2005 Wisconsin Act 25, the 2005-07 biennial budget, BadgerCare has expanded coverage to the following individuals:

- Pregnant non-U.S. citizens who are not qualified aliens but meet other eligibility criteria for BadgerCare.
- Pregnant individuals detained by legal process who meet other eligibility criteria for BadgerCare.

The BadgerCare Expansion for Certain Pregnant Women is designed to provide better birth outcomes.

Women are eligible for all covered services from the first of the month in which their pregnancy is verified or the first of the month in which the application for BadgerCare Plus is filed, whichever is later. Members are enrolled through the last day of the month in which they deliver or the pregnancy ends. Postpartum care is reimbursable *only* if provided as part of global obstetric care. Even though enrollment is based on pregnancy, these women are eligible for *all* covered services. (They are not limited to pregnancy-related services.)

These women are not presumptively eligible. Providers should refer them to the appropriate county/tribal social or human services agency where they can apply for this coverage.

Fee-for-Service

Pregnant non-U.S. citizens who are not qualified aliens and pregnant individuals detained by legal process receive care only on a fee-for-service basis. Providers are required to follow all program requirements (e.g., claims submission procedures, PA (prior authorization) requirements) when providing services to these women.

Emergency Services for Non-U.S. Citizens

When BadgerCare Plus enrollment ends for pregnant non-U.S. citizens who are not qualified aliens, they receive coverage for emergency services. These women receive emergency coverage for 60 days after the pregnancy ends; this coverage continues through the end of the month in which the 60th day falls (e.g., a woman who delivers on June 20, 2006, would be enrolled through the end of August 2006).

Topic #9297

BadgerCare Plus Basic Plan

The BadgerCare Plus Basic Plan is a self-funded plan that focuses on providing BadgerCare Plus Core Plan waitlist members with access to vital, cost-effective primary and preventive care. This option will allow members to have some minimal form of coverage until space becomes available in the Core Plan and will help prevent bankruptcy due to excessive medical debt.

Member participation or non-participation in the Basic Plan does not affect an individual's status on the Core Plan waitlist.

Services for the Basic Plan are covered under fee-for-service. Basic Plan members will not be enrolled in state-contracted HMOs (health maintenance organizations).

As of March 19, 2011, new enrollment into the Basic Plan ended. The Basic Plan will continue for members already enrolled in the Basic Plan.

Conditions That End Member Enrollment in the Basic Plan

A member's enrollment in the Basic Plan will end if the member:

- Becomes eligible for Medicare, Medicaid, the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, or the Core Plan.
- Becomes incarcerated or becomes institutionalized in an IMD (institution for mental disease).
- Becomes pregnant. (*Note:* A Basic Plan member who becomes pregnant should be referred to [Member Services](#) for more information about enrollment in the Standard Plan or the Benchmark Plan.)
- No longer resides in the state of Wisconsin.
- Obtains health insurance coverage.
- Turns 65 years of age.
- Fails to pay the monthly premium.

Note: Enrollment in the Basic Plan does not end if the member's income increases.

Providers are reminded that the Basic Plan does not cover obstetrical services or delivery services.

Providers are required to notify ForwardHealth if they have reason to believe that a person is misusing or abusing BadgerCare Plus or Medicaid benefits or the ForwardHealth identification card.

Basic Plan Member Fact Sheets

[Fact sheets](#) providing additional member information about the Basic Plan are available.

Enrollment Certification Period for Basic Plan Members

A member's enrollment will begin on the first of the month and will continue through the end of the 12th month. For example, if the individual's enrollment in the Basic Plan begins on July 1, 2010, the enrollment certification period will continue through June 30, 2011, unless conditions occur that end enrollment.

Premium payments are due on the fifth of each month, prior to the month of coverage. Members who fail to pay the monthly premium will have their benefits terminated and will also be subject to a 12-month restrictive re-enrollment period.

Basic Plan Members Enrolled in Wisconsin Chronic Disease Program

For Basic Plan members who are also enrolled in WCDP (Wisconsin Chronic Disease Program), providers should submit claims for all covered services to the Basic Plan first and then to WCDP. For pharmacy services, if both programs deny the pharmacy claim, providers should submit the claim to BadgerRx Gold.

Basic Plan Members and HIRSP Coverage

Basic Plan members may also be enrolled in the HIRSP (Health Insurance Risk-Sharing Plan) as long as the member meets the eligibility requirements for both the Basic Plan and HIRSP. For Basic Plan members who are also enrolled in HIRSP, providers should submit claims for all Basic Plan covered services to HIRSP first and then to the Basic Plan.

Basic Plan members may not be enrolled in the Basic Plan and the Federal Temporary High Risk Insurance Pool. Information that

is being distributed to Core Plan members on the waitlist regarding HIRSP and the Federal Temporary High Risk Insurance Pool is [available](#).

Alternatives to the BadgerCare Plus Basic Plan

Before enrolling in the BadgerCare Plus Basic Plan, you should consider two other insurance options available to some Wisconsin residents. Enrolling in BadgerCare Plus Basic will make you ineligible for coverage under the Federal Pool option described below.

Option 1: Health Insurance Risk-Sharing Plan (HIRSP)

You may qualify for HIRSP if:

1. You recently lost your employer-sponsored insurance coverage; or
2. You have been rejected for coverage in the private insurance market; or
3. You have HIV/AIDS; or
4. You have Medicare because of a disability.

HIRSP offers comprehensive medical and pharmacy benefits including coverage of brand name drugs and \$150 of first dollar coverage on routine/preventive services. HIRSP will not cover medical services for a preexisting condition for the first six months of coverage. The preexisting condition waiting period does not apply to drug coverage. The medical services preexisting condition waiting period does not apply if you qualify for HIRSP because you have recently lost your employer-sponsored coverage.

If your annual household income is below \$33,000, you may be entitled to a premium and deductible subsidy. For example, a 25 year old man with an annual income of less than \$10,000 would pay \$89 per month for a \$2,500 deductible insurance plan.

HIRSP members can also be enrolled in the BadgerCare Plus Basic or Core Plan.

Option 2: Federal Temporary High Risk Insurance Pool

You may qualify for the new Federal Pool if:

1. You are a citizen or national of the United States, or are lawfully present;
2. You have a preexisting medical condition; and
3. You have been uninsured for at least 6 months before applying for coverage.

The Federal Pool will offer the same medical and drug benefits as HIRSP. There is no preexisting condition waiting period under the Federal Pool.

In most cases, the Federal Pool premium will be lower than the HIRSP premium.
Enrollment is expected to begin in July 2010, for coverage beginning August 1, 2010.

If you enroll in BadgerCare Plus Basic or HIRSP now, you will not be eligible for the Federal Pool. You should determine which program best serves your needs. For more information about HIRSP or the Federal Pool and your insurance options, please contact HIRSP Customer Service at 1.800.828.4777 or visit www.hirsp.org

Topic #5557

BadgerCare Plus Core Plan

The BadgerCare Plus Core Plan covers basic health care services including primary care, preventive care, certain generic and OTC (over-the-counter) drugs, and a limited number of brand name drugs.

Applicant Enrollment Requirements

An applicant must meet the following enrollment requirements in order to qualify for the Core Plan:

- Is a Wisconsin resident.
- Is a United States citizen or legal immigrant.
- Is between the ages of 19 and 64.
- Does not have any children under age 19 under his or her care.
- Is not pregnant.
- Is not eligible for or enrolled in Medicaid, the BadgerCare Plus Standard Plan, or the BadgerCare Plus Benchmark Plan. This would not include benefits provided under Family Planning Only Services or those benefits provided to individuals who qualify for the TB-Only (Tuberculosis-Related Services Only) Benefit.
- Is not eligible for or enrolled in Medicare.
- Has a monthly gross income that does not exceed 200 percent of the FPL (Federal Poverty Level).
- Is not covered by health insurance currently or in the previous 12 months.
- Has not had access to employer-sponsored insurance in the previous 12 months and does not have access to employer-subsidized insurance during the month of application or any of the three months following application.

Application Process for New Members

Individuals who wish to enroll may apply for the Core Plan [using the ACCESS tool online](#) or via the [ESC \(Enrollment Services Center\)](#). A pre-screening tool will help determine which individuals may be eligible to enroll in the Core Plan. Applications for Core Plan members will be processed centrally by the ESC, not by county agencies.

To complete the application process, applicants must meet the following requirements:

- Complete a Health Survey.
- Pay a non-refundable, annual processing fee of \$60.00 per individual or per couple for married couples. The fee will be waived for homeless individuals. There are no monthly premiums.

Medicaid-enrolled providers cannot pay the \$60.00 application processing fee on behalf of Core Plan applicants. An offer by a Medicaid-enrolled provider to pay a fee on behalf of a prospective Medicaid member may violate federal laws against kickbacks. These laws are federal criminal statutes that are interpreted and enforced by federal agencies such as the United States DOJ (Department of Justice) and the Department of HHS (Health and Human Services') OIG (Office of the Inspector General).

Conditions That End Member Enrollment in the Core Plan

A member's enrollment will end if the member:

- Becomes eligible for Medicare, Medicaid, the Standard Plan, or the Benchmark Plan.
- Becomes incarcerated or institutionalized in an IMD (institution for mental disease).
- Becomes pregnant.
- No longer resides in the state of Wisconsin.
- Obtains health insurance coverage.
- Turns 65 years of age.

Providers are reminded that the Core Plan does not cover obstetrical services, including the delivery of a child or children. A Core Plan member who becomes pregnant should be referred to the ESC for more information about enrollment in the Standard Plan or the Benchmark Plan.

Enrollment Certification Period for Core Plan Members

Once determined eligible for enrollment in the Core Plan, a member's enrollment will begin either on the first or 15th of the month, whichever is first, and will continue through the end of the 12th month. For example, if the individual submits all of his or her application materials, including the application fee, by September 17, 2009, and the DHS (Department of Health Services) reviews the application and approves it on October 6, 2009, the individual is eligible for enrollment beginning on October 15, 2009, the next possible date of enrollment. The enrollment certification period will continue through October 31, 2010.

The enrollment certification period for individuals who qualify for the Core Plan is 12 months, regardless of income changes.

Core Plan Members Enrolled in Wisconsin Chronic Disease Program

For Core Plan members who are also enrolled in WCDP (Wisconsin Chronic Disease Program), providers should submit claims for all covered services to the Core Plan first and then to WCDP. For pharmacy services, if both programs deny the pharmacy claim, providers should submit claims to BadgerRx Gold.

Core Plan Members with HIRSP Coverage

Core Plan members may also be enrolled in HIRSP (Health Insurance Risk Sharing Plan) as long as the member meets the eligibility requirements for both the Core Plan and HIRSP. For Core Plan members who are also enrolled in HIRSP, providers should submit claims for all Core Plan covered services to the Core Plan. For services not covered by the Core Plan, providers should submit claims to HIRSP. For members enrolled in the Core Plan, HIRSP is always the payer of last resort.

Note: HIRSP will only cover noncovered Core Plan services if the services are covered under the HIRSP benefit.

Topic #225

BadgerCare Plus Standard Plan and Benchmark Plan

BadgerCare Plus is a state-sponsored health care program that expands coverage of Wisconsin residents and ensures that all children in Wisconsin have access to affordable health care.

The key initiatives of BadgerCare Plus are:

- To ensure that all Wisconsin children have access to affordable health care.
- To ensure that 98 percent of Wisconsin residents have access to affordable health care.
- To streamline program administration and enrollment rules.
- To expand coverage and provide enhanced benefits for pregnant women.
- To promote prevention and healthy behaviors.

BadgerCare Plus expands enrollment in state-sponsored health care to the following:

- All uninsured children.
- More pregnant women.
- More parents and caretaker relatives.
- Parents with children in foster care who are working to reunify their families.
- Young adults exiting out-of-home care, such as foster care, because they have turned 18 years of age.

- Certain farmers and other self-employed parents and caretaker relatives.

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

Topic #6917

Benefit Plans Under BadgerCare Plus

BadgerCare Plus is comprised of four benefit plans, the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, and the BadgerCare Plus Basic Plan.

BadgerCare Plus Standard Plan

The Standard Plan covers children, parents and caretaker relatives, young adults aging out of foster care, and pregnant women with incomes at or below 200 percent of the FPL (Federal Poverty Level). The services covered under the Standard Plan are the same as the Wisconsin Medicaid program.

BadgerCare Plus Benchmark Plan

The Benchmark Plan was adapted from Wisconsin's largest commercial, low-cost health care plan. The Benchmark Plan is for children and pregnant women with incomes above 200 percent of the FPL and certain self-employed parents, such as farmers with incomes above 200 percent of the FPL. The services covered under the Benchmark Plan are more limited than those covered under the Wisconsin Medicaid program.

BadgerCare Plus Core Plan

The Core Plan provides adults who were previously not eligible to enroll in state and federal health care programs with access to basic health care services including primary care, preventive care, certain generic and OTC (over-the-counter) drugs, and a limited number of brand name drugs.

BadgerCare Plus Basic Plan

The Basic Plan provides Core Plan waitlist members with access to vital, cost-effective primary and preventive care. This option allows members to have some form of minimal coverage until space becomes available in the Core Plan.

Topic #230

Express Enrollment for Children and Pregnant Women

The EE (Express Enrollment) for Pregnant Women Benefit is a limited benefit category that allows a pregnant woman to receive immediate pregnancy-related outpatient services while her application for full-benefit BadgerCare Plus is processed. Enrollment is not restricted based on the member's other health insurance coverage. Therefore, a pregnant woman who has other health insurance may be enrolled in the benefit.

The EE for Children Benefit allows certain members through 18 years of age to receive BadgerCare Plus benefits under the BadgerCare Plus Standard Plan while an application for BadgerCare Plus is processed.

Fee-for-Service

Women and children who are temporarily enrolled in BadgerCare Plus through the EE process are not eligible for enrollment in an HMO until they are determined eligible for full benefit BadgerCare Plus by the county/tribal office.

Topic #226

Family Planning Only Services

Family Planning Only Services is a limited benefit program that provides routine contraceptive-related services to low-income individuals who are at least 15 years of age who are otherwise not eligible for Wisconsin Medicaid or BadgerCare Plus. There is no upper age limit for Family Planning Only Services enrollment as long as the member is of childbearing age. Members receiving Family Planning Only Services must be receiving routine contraceptive-related services.

The goal of Family Planning Only Services is to provide members with information and services to assist them in preventing pregnancy, making BadgerCare Plus enrollment due to pregnancy less likely. Providers should explain the purpose of Family Planning Only Services to members and encourage them to contact their certifying agency to determine their enrollment options if they are not interested in, or do not need, contraceptive services.

Members enrolled in Family Planning Only Services receive routine services to prevent or delay pregnancy and are not eligible for other services (e.g., PT (physical therapy) services, dental services). Even if a medical condition is discovered during a family planning visit, treatment for the condition is not covered under Family Planning Only Services unless the treatment is identified in the list of [allowable procedure codes](#) for Family Planning Only Services.

Members are also not eligible for certain other services that are covered under the Wisconsin Medicaid and BadgerCare Plus family planning benefit (e.g., mammograms and hysterectomies). If a medical condition, other than an STD (sexually transmitted disease), is discovered during contraceptive-related services, treatment for the medical condition is not covered under Family Planning Only Services.

Colposcopies and treatment for STDs are only covered through Family Planning Only Services if they are determined medically necessary during routine contraceptive-related services. A colposcopy is a covered service when an abnormal result is received from a pap test, prior to the colposcopy, while the member is enrolled in Family Planning Only Services and receiving contraceptive-related services.

Family Planning Only Services members diagnosed with cervical cancer, precancerous conditions of the cervix, or breast cancer may be eligible for Wisconsin Well Woman Medicaid. Providers should assist eligible members with the enrollment process for Well Woman Medicaid.

Providers should inform members about other service options and provide referrals for care not covered by Family Planning Only Services.

Temporary Enrollment for Family Planning Only Services

Members whose providers are submitting an initial Family Planning Only Services application on their behalf and who meet the enrollment criteria may receive routine contraceptive-related services immediately through TE (temporary enrollment) for Family Planning Only Services for up to two months. Services covered under the TE for Family Planning Only Services are the same as those covered under Family Planning Only Services and must be related to routine contraceptive management.

To determine enrollment for Family Planning Only Services, providers should use the income limit for 300 percent of the [FPL \(Federal Poverty Level\)](#).

TE for Family Planning Only Services providers may issue white paper TE for Family Planning Only Services identification cards for members to use until they receive a ForwardHealth identification card. Providers should remind members that the benefit is

temporary, despite their receiving a ForwardHealth card.

Topic #4757

ForwardHealth and ForwardHealth interChange

ForwardHealth brings together many DHS (Department of Health Services) health care programs with the goal to create efficiencies for providers and to improve health outcomes for members. ForwardHealth interChange is the DHS claims processing system that supports multiple state health care programs and Web services, including:

- BadgerCare Plus.
- BadgerCare Plus and Medicaid managed care programs.
- SeniorCare.
- 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, HP (Hewlett-Packard).

Topic #229

Limited Benefit Categories Overview

Certain members may be enrolled in a limited benefit category. These limited benefit categories include the following:

- BadgerCare Plus Expansion for Certain Pregnant Women.
- EE (Express Enrollment) for Children.
- EE for Pregnant Women.
- Family Planning Only Services, including TE (Temporary Enrollment) for Family Planning Only Services.
- QDWI (Qualified Disabled Working Individuals).
- QI-1 (Qualifying Individuals 1).
- QMB Only (Qualified Medicare Beneficiary Only).
- SLMB (Specified Low-Income Medicare Beneficiary).
- TB-Only (Tuberculosis-Related Services-Only) Benefit.

Members may be enrolled in full-benefit Medicaid or BadgerCare Plus and also be enrolled in certain limited benefit programs, including QDWI, QI-1, QMB Only, and SLMB. In those cases, a member has full Medicaid or BadgerCare Plus coverage in addition to limited coverage for Medicare expenses.

Members enrolled in BadgerCare Plus Expansion for Certain Pregnant Women, Family Planning Only Services, EE for Children, EE for Pregnant Women, or the TB-Only Benefit cannot be enrolled in full-benefit Medicaid or BadgerCare Plus. These members receive benefits through the limited benefit category.

Providers should note that a member may be enrolled in more than one limited benefit category. For example, a member may be enrolled in Family Planning Only Services and the TB-Only Benefit.

Providers are strongly encouraged to verify dates of enrollment and other coverage information using the EVS (Wisconsin's Enrollment Verification System) to determine whether a member is in a limited benefit category, receives full-benefit Medicaid or

BadgerCare Plus, or both.

Providers are responsible for knowing which services are covered under a limited benefit category. If a member of a limited benefit category requests a service that is not covered under the limited benefit category, the provider may collect payment from the member if certain [conditions](#) are met.

Topic #228

Medicaid

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

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

A Medicaid member is any individual entitled to benefits under Title XIX of the Social Security Act and under the Medical Assistance State Plan as defined in ch. [49](#), Wis. Stats.

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

- Age 65 and older.
- Blind.
- Disabled.

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

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

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

- Local county or tribal agencies.
- Medicaid outstation sites.
- SSA (Social Security Administration) offices.

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

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

Topic #10217

Members Enrolled in the Wisconsin Well Woman Program and the BadgerCare Plus Basic Plan

Women may be enrolled in the WWWP (Wisconsin Well Woman Program) and the BadgerCare Plus Basic Plan at the same time. Women who are diagnosed with breast cancer or cervical cancer while enrolled in WWWP are eligible to be enrolled in WWWMA (Wisconsin Well Woman Medicaid) through the WWWP. WWWMA covers the same services as Wisconsin Medicaid; therefore, enrollment in WWWMA enables members to receive comprehensive treatment, including services not related to their diagnosis.

Once a woman is enrolled in WWWMA, she is no longer eligible for the Basic Plan.

Topic #232

Qualified Disabled Working Individual Members

QDWI (Qualified Disabled Working Individual) members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part A.

QDWI members are certified by their local county or tribal agency. To qualify, QDWI members are required to meet the following qualifications:

- Have income under 200 percent of the FPL (Federal Poverty Level).
- Be entitled to, but not necessarily enrolled in, Medicare Part A.
- Have income or assets too high to qualify for QMB-Only (Qualified Medicare Beneficiary-Only) and SLMB (Specified Low-Income Medicare Beneficiaries).

Topic #234

Qualified Medicare Beneficiary-Only Members

QMB-Only (Qualified Medicare Beneficiary-Only) members are a limited benefit category of Medicaid members. They receive payment of the following:

- Medicare monthly premiums for Part A, Part B, or both.
- Coinsurance, copayment, and deductible for Medicare-allowed services.

QMB-Only members are certified by their local county or tribal agency. QMB-Only members are required to meet the following qualifications:

- Have an income under 100 percent of the FPL (Federal Poverty Level).
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Topic #235

Qualifying Individual 1 Members

QI-1 (Qualifying Individual 1) members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part B.

QI-1 members are certified by their local county or tribal agency. To qualify, QI-1 members are required to meet the following qualifications:

- Have income between 120 and 135 percent of the FPL (Federal Poverty Level).
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Topic #236

Specified Low-Income Medicare Beneficiaries

SLMB (Specified Low-Income Medicare Beneficiary) members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part B.

SLMB members are certified by their local county or tribal agency. To qualify, SLMB members are required to meet the following qualifications:

- Have an income under 120 percent of the FPL (Federal Poverty Level).
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Topic #262

Tuberculosis-Related Services-Only Benefit

The [TB-Only \(Tuberculosis-Related Services-Only\) Benefit](#) is a limited benefit category that allows individuals with TB (tuberculosis) infection or disease to receive covered TB-related outpatient services.

Topic #240

Wisconsin Well Woman Medicaid

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

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

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

Members Enrolled into Wisconsin Well Woman Medicaid from Benchmark Plan or Core Plan

Women diagnosed with breast cancer or cervical cancer while enrolled in the BadgerCare Plus Benchmark Plan or BadgerCare Plus Core Plan are eligible to be enrolled in WWWMA. Wisconsin Well Woman Medicaid covers the same services as Wisconsin Medicaid and enables members to receive comprehensive treatment, including services not related to their diagnosis.

Women who are diagnosed with breast cancer, cervical cancer, or a precancerous condition of the cervix must have the diagnosis

of their condition confirmed by one of the following Medicaid-enrolled providers:

- Nurse practitioners, for cervical conditions only.
- Osteopaths.
- Physicians.

Women with Medicare or other insurance that covers treatment for her cancer are not allowed to be enrolled into WWWMA.

Covered and Noncovered Services

Wisconsin Well Woman Medicaid covers the same services as Wisconsin Medicaid regardless of whether the service is related to her cancer treatment.

Reimbursement

Providers will be reimbursed for services provided to members enrolled in WWWMA at the Wisconsin Medicaid rate of reimbursement for covered services.

Copayments

There are no copayments for any Medicaid-covered service for WWWMA members who have been enrolled into WWWMA from the Benchmark or the Core Plan. Providers are required to reimburse members for any copayments members paid on or after the date of diagnosis while still enrolled in the Benchmark Plan or the Core Plan.

Topic #7418

Wisconsin Well Woman Medicaid Enrollment from the Benchmark Plan or the Core Plan

To enroll a woman to WWWMA (Wisconsin Well Woman Medicaid) from the Benchmark Plan or the Core Plan, the woman, along with the authorized diagnosing provider, is required to complete and sign the Wisconsin Well Woman Medicaid Determination (F-10075 (12/09)) form. The form may be obtained from the Wisconsin Department of Health Services [Forms Library](#).

The form should be faxed to the CAPO (Central Application Processing Operation) at (608) 267-3381 or sent via email to dhsemcapo@wisconsin.gov.

Typically, CAPO will process the WWWMA form in 10 business days but not longer than 30 calendar days from the receipt of the form. Once the determination is processed, the member's enrollment information will be updated for providers to verify the member's status via the ForwardHealth Portal or [WiCall](#).

Recertification of Enrollment

Members must complete an annual review for continued enrollment in WWWMA. Members will receive a written notice approximately 45 days prior to the last day of their enrollment. The member is required to submit a new Wisconsin Well Woman Medicaid Determination form signed by her physician attesting to the need for ongoing treatment.

Backdating

Enrollment in WWWMA may be backdated to the date of diagnosis, but not to a date earlier than the first date of the women's

enrollment in the Benchmark Plan or the Core Plan.

Enrollment Responsibilities

Topic #241

General Information

Members have certain responsibilities per [DHS 104.02](#), Wis. Admin. Code, and the [ForwardHealth Enrollment and Benefits \(P-00079 \(10/11\)\)](#) booklet.

Topic #243

Loss of Enrollment — Financial Liability

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

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

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

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

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

Topic #707

Member Cooperation

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

Topic #269

Members Should Present Card

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

receiving services.

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

Topic #244

Prior Identification of Enrollment

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

Topic #245

Reporting Changes to Caseworkers

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

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

Enrollment Rights

Topic #246

Appealing Enrollment Determinations

Applicants and members have the right to appeal certain decisions relating to BadgerCare Plus, 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 [HA 3.03](#), Wis. Admin. Code, an applicant, member, or former member may appeal any adverse action or decision by an agency or department that affects their benefits. Examples of decisions that may be appealed include, but are not limited to, the following:

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

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

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

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

Claims for Appeal Reversals

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

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

ForwardHealth
Specialized Research
Ste 50
313 Blettner Blvd
Madison WI 53784

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

As a reminder, claims [submission deadlines](#) still apply even to those claims with hearing decisions.

Claim Denial Due to Termination of ADAP Enrollment

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

ForwardHealth
ADAP Claims and Adjustments
PO Box 8758
Madison WI 53708

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

As a reminder, claims [submission deadlines](#) still apply even to those claims with hearing decisions.

Topic #247

Freedom of Choice

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

Topic #248

General Information

Members are entitled to certain rights per [DHS 103](#), Wis. Admin. Code.

Topic #250

Notification of Discontinued Benefits

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

Topic #252

Prompt Decisions on Enrollment

Individuals applying for BadgerCare Plus or Wisconsin Medicaid have the right to prompt decisions on their applications. Enrollment decisions are made within 60 days of the date the application was signed for those with disabilities and within 30 days for all other applicants.

Topic #254

Requesting Retroactive Enrollment

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

Identification Cards

Topic #9357

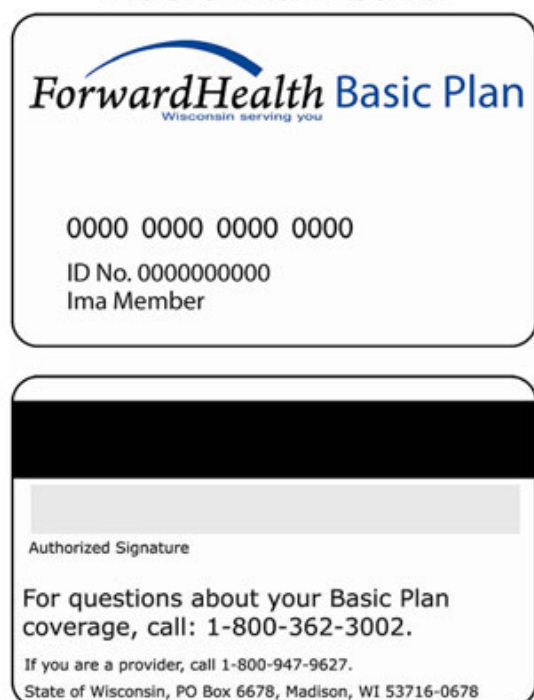
ForwardHealth Basic Plan Identification Cards

Members enrolled in the BadgerCare Plus Basic Plan will receive a [ForwardHealth Basic Plan card](#). All identification cards include the member's name and 10-digit member identification number. The identification cards may be used to verify a member's enrollment, but possession of an identification card does not guarantee enrollment. It is possible that a member will present a card when he or she is not enrolled; therefore, it is essential that providers verify enrollment before providing services.

Providers should always check enrollment for a member who presents a ForwardHealth card to verify if the member is enrolled in the Basic Plan or in one of the other ForwardHealth programs. (Providers may use the same methods of enrollment verification under the Basic Plan as they do for other ForwardHealth programs such as Medicaid. These methods include the ForwardHealth Portal, WiCall, magnetic stripe readers, and the 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response) transactions.) Members who present a ForwardHealth card or a ForwardHealth Basic Plan card may have been enrolled in a different plan since the card was issued. Providers should be careful to verify the plan in which the member is enrolled and know which services are covered under that plan.

Basic Plan members should call [Member Services](#) with questions about premiums and covered services. The ForwardHealth Basic Plan cards include the Member Services telephone number on the back.

Sample ForwardHealth Basic Plan Card



Topic #6977

ForwardHealth Core Plan Identification Cards

Members enrolled in the BadgerCare Plus Core Plan will receive a [ForwardHealth Core Plan card](#). All identification cards include the member's name and 10-digit member identification number. The identification cards may be used to verify a member's enrollment, but possession of an identification card does not guarantee enrollment. It is possible that a member will present a card when he or she is not enrolled; therefore, it is essential that providers verify enrollment before providing services.

Core Plan members should call [Member Services](#) with questions about enrollment criteria, HMO (health maintenance organization) enrollment, and covered services.

Providers should always check enrollment for a member who presents a ForwardHealth card to verify if the member is enrolled in the Core Plan or in one of the other ForwardHealth programs. Members who present a ForwardHealth card or a ForwardHealth Core Plan card may have been enrolled in a different plan since the card was issued. Providers should be careful to verify the plan in which the member is enrolled and know which services are covered under that plan.

Sample ForwardHealth Core Plan Card



Topic #266

ForwardHealth Identification Cards

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

ForwardHealth Identification Card Features

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

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

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

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

Identification Number Changes

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

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

Member Name Changes

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

Deactivated Cards

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

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

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

Defective Cards

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

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

Lost Cards

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

If a member lost his or her ForwardHealth card or never received one, the member may call [Member Services](#) to request a new one.

Managed Care Organization Enrollment Changes

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

Sample ForwardHealth Identification Card



Topic #268

Temporary Enrollment for Family Planning Only Services Identification Cards

Qualified providers may issue white paper TE (Temporary Enrollment) for Family Planning Only Services identification cards for members to use temporarily until they receive a ForwardHealth identification card. The identification card is included with the TE for Family Planning Only Services Application (F-10119).

The TE for Family Planning Only Services identification cards have the following message printed on them: "Temporary Identification Card for Temporary Enrollment for Family Planning Only Services." Providers should accept the white TE for Family Planning Only Services identification cards as proof of enrollment for the dates provided on the cards and are encouraged to keep a photocopy of the card.

Topic #267

Temporary Express Enrollment Cards

There are two types of temporary EE (Express Enrollment) identification cards. One is issued for pregnant women and the other for children that are enrolled in BadgerCare Plus through EE. The EE cards are valid for 14 days. [Samples of temporary EE cards](#) for children and pregnant women are available.

Providers may assist pregnant women with filling out an application for temporary ambulatory prenatal care benefits through the online EE process. EE identification cards are included on the bottom portion of the enrollment notice that is printed out and provided to the member after the online enrollment process is completed.

The paper application may also be used to apply for temporary ambulatory prenatal benefits for pregnant women. A beige paper identification card is attached to the last page of the application and provided to the woman after she completes the enrollment process.

The online EE process is also available for adults to apply for full BadgerCare Plus benefits for children. EE identification cards are included on the bottom portion of the enrollment notice that is printed out and provided to the member after the online enrollment process is completed. This temporary identification card is different, since providers may see more than one child listed if multiple children in one household are enrolled through EE. However, each child will receive his or her own ForwardHealth card after the application is submitted.


Each member who is enrolled through EE will receive a ForwardHealth card usually within three business days after the EE application is submitted and approved. To ensure children and pregnant women receive needed services in a timely manner, providers should accept the printed paper EE cards for children and either the printed paper EE card or the beige identification cards for pregnant women as proof of enrollment for the dates provided on the cards. Providers may use Wisconsin's EVS (Enrollment Verification System) to verify enrollment for DOS (dates of service) after those printed on the card. Providers are encouraged to keep a photocopy of the card.

Sample Express Enrollment Cards

Which benefit?	Status of your benefits?
 <p>BadgerCare Plus temporary enrollment for pregnant women</p>	<p>You applied for BadgerCare Plus Express Enrollment on 06/26/2008. You are temporarily enrolled in BadgerCare Plus for outpatient pregnancy-related services. Your enrollment will end on or before 07/31/2008. To learn more, see your Rights and Responsibilities.</p> <p>To get regular BadgerCare Plus or Wisconsin Medicaid, you must apply online, by mail or in person:</p> <ul style="list-style-type: none"> Online at http://access.wi.gov By mail or in person at: Dane County Job Center 1819 Aberg Ave. Madison, WI 53704 (608) 242-7400

To learn more, see your Rights and Responsibilities.

<p>To the Provider</p> <p>The individual listed has been temporarily enrolled through BadgerCare Plus Express Enrollment in accordance with Wis. Stat. s. 49.471. This card entitles this individual to receive pregnancy related outpatient care including pharmacy services through BadgerCare Plus from any certified BadgerCare Plus provider for the period specified on this card. (See card effective dates.) For additional information, call Provider Services at (800) 947-9627 or see the All Provider Handbook.</p> <p>NOTE:</p> <p>It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services as long as other reimbursement requirements are met. All policies regarding covered services apply during the temporary enrollment period, including the prohibition against billing recipients. Refer to the All Provider Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.</p>	<p>WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES</p> <p>IDENTIFICATION CARD FOR TEMPORARY ENROLLMENT IN BADGERCARE PLUS FOR PREGNANT WOMEN</p>  <p>Name: Jane Smith ID Number: 0454782131</p> <p>Effective Dates: 06/26/2008- 07/31/2008</p>
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Which benefit?	Status of your benefits?
 <p>BadgerCare Plus temporary enrollment for children</p>	<p>You applied for BadgerCare Plus Express Enrollment on 06/26/2008. The following individual(s) is/are temporarily enrolled in BadgerCare Plus:</p> <ul style="list-style-type: none"> Joe Smith Sara Smith <p>This temporary enrollment will end on or before 07/31/2008. To learn more, see your Rights and Responsibilities. In order to continue receiving BadgerCare Plus you must apply through one of the following methods:</p> <ul style="list-style-type: none"> Online at http://access.wi.gov By mail or in person at: Dane County Job Center 1819 Aberg Ave. Madison, WI 53704 (608) 242-7400

To learn more, see your Rights and Responsibilities.

<p>To the Provider</p> <p>The children listed have been temporarily enrolled through BadgerCare Plus Express Enrollment in accordance with Wis. Stat. s. 49.471. This card entitles this individual to receive services through BadgerCare Plus from any certified BadgerCare Plus provider for the period specified on this card. (See card effective dates.) For additional information, call Provider Services at (800) 947-9627 or see the All Provider Handbook.</p> <p>NOTE:</p> <p>It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services as long as other reimbursement requirements are met. All policies regarding covered services apply during the temporary enrollment period, including the prohibition against billing recipients. Refer to the All Provider Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.</p>	<p>WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES</p> <p>IDENTIFICATION CARD FOR TEMPORARY ENROLLMENT IN BADGERCARE PLUS FOR CHILDREN</p>  <table> <tr> <td>Name:</td> <td>ID Number:</td> </tr> <tr> <td>Joe Smith</td> <td>0321434543</td> </tr> <tr> <td>Sara Smith</td> <td>0787451231</td> </tr> </table> <p>Effective Dates: 06/26/2008- 07/31/2008</p>	Name:	ID Number:	Joe Smith	0321434543	Sara Smith	0787451231
Name:	ID Number:						
Joe Smith	0321434543						
Sara Smith	0787451231						

Topic #1435

Types of Identification Cards

ForwardHealth members receive an identification card upon initial eligibility determination. Identification cards may be in any of the following formats:

- White plastic ForwardHealth cards.
- White plastic ForwardHealth Core Plan cards.
- White plastic ForwardHealth Basic Plan cards.
- White plastic SeniorCare cards.
- Paper printout temporary card for EE (Express Enrollment) for children.
- Paper printout temporary card for EE for pregnant women.
- Beige paper temporary card for EE for pregnant women.
- White paper TE (Temporary Enrollment) for Family Planning Only Services cards.

Misuse and Abuse of Benefits

Topic #271

Examples of Member Abuse or Misuse

Examples of member abuse or misuse are included in [DHS 104.02\(5\)](#), Wis. Admin. Code.

Topic #274

Pharmacy Services Lock-In Program

Overview of the Pharmacy Services Lock-In Program

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

Coordination of member health care services is intended to:

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

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

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

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

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

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

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

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

Medicaid, BadgerCare Plus, and SeniorCare members who are candidates for enrollment in the Pharmacy Services Lock-In Program are sent a letter of intent, which explains the restriction that will be applied, how to designate a primary prescriber and a pharmacy, and how to request a hearing if they wish to contest the decision for enrollment (i.e., due process). If a member fails to designate providers, the Pharmacy Services Lock-In Program may assign providers based on claims' history. In the letter of intent, members are also informed that access to emergency care is not restricted.

Letters of notification are sent to the member and to the lock-in primary prescriber and pharmacy. Providers may designate alternate prescribers or pharmacies for restricted medications, as appropriate. Members remain in the Pharmacy Services Lock-In Program for two years. The primary lock-in prescriber and pharmacy may make referrals for specialist care or for care that they are otherwise unable to provide (e.g., home infusion services). The member's utilization of services is reviewed prior to release from the Pharmacy Services Lock-In Program, and lock-in providers are notified of the member's release date.

Excluded Drugs

The following scheduled drugs will be excluded from monitoring by the Pharmacy Services Lock-In Program:

- Anabolic steroids.
- Barbiturates used for seizure control.
- Lyrica[®].
- Provigil[®] and Nuvigil[®].
- Weight loss drugs.

Pharmacy Services Lock-In Program Administrator

The Pharmacy Services Lock-In Program is administered by HID (Health Information Designs, Inc.). HID may be contacted by telephone at (800) 225-6998, extension 3045, by fax at (800) 881-5573, or by mail at the following address:

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

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

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

Role of the Lock-In Prescriber and Pharmacy Provider

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

medications using his or her professional discretion, and designates an alternate prescriber if needed. If the member requires an alternate prescriber to prescribe restricted medications, the primary prescriber should complete the [Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services \(F-11183 \(12/10\)\)](#) form and return it to the Pharmacy Services Lock-In Program and to the member's HMO, if applicable.

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

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

Designated Lock-In Pharmacies

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

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

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

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

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

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

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

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

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

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

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

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

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

For More Information

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

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

Topic #273

Providers May Refuse to Provide Services

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

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

Topic #275

Requesting Additional Proof of Identity

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

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

Special Enrollment Circumstances

Topic #276

Medicaid Members from Other States

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

Topic #279

Members Traveling Out of State

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

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

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

Topic #552

Newborn Reporting

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

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

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

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

Newborn Report Submission

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

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

Providers may report the birth of a baby by submitting the [Newborn Report \(F-1165 \(06/11\)\)](#) form or submitting the information in another format as long as all information required on the Newborn Report form is provided. Required information includes the following:

- Provider's name.
- Contact name and telephone number.
- Baby's last name.
- Baby's gender.
- Baby's date of birth (in MM/DD/CCYY format).
- Indication if newborn weight is less than 1200 grams.
- Newborn weight.*
- Gestational age.*
- Mother's full name.
- Mother's member ID (identification) 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 him or her of the child's enrollment.

Babies Born to Mothers Not Enrolled in BadgerCare Plus or Medicaid

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

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

Providers with questions regarding newborn enrollment or newborn reporting may call [Provider Services](#).

Topic #277

Non-U.S. Citizens — Emergency Services

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

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

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

Due to federal regulations, BadgerCare Plus and Wisconsin Medicaid do not cover services for non-U.S. citizens who are not qualified aliens related to routine prenatal or postpartum care, major organ transplants (e.g., heart, liver), or ongoing treatment for chronic conditions where there is no evidence of an acute emergent state. For the purposes of this policy, all labor and delivery is considered an emergency service.

Note: Babies born to certain non-qualifying immigrants are eligible for Medicaid enrollment under the CEN (continuously eligible newborn) option. However, babies born to women with incomes over 300 percent of the FPL (Federal Poverty Level) are not eligible for CEN status. The baby may still qualify for BadgerCare Plus. These mothers should report the birth to the local agencies within ten calendar days.

A provider who gives emergency care to a non-U.S. citizen should refer him or her to the local county or tribal agency or ForwardHealth outpost site for a determination of BadgerCare Plus enrollment. Providers may complete the [Certification of Emergency for Non-U.S. Citizens \(F-1162 \(02/09\)\)](#) form for clients to take to the local county or tribal agency in their county of

residence where the BadgerCare Plus enrollment decision is made.

Providers should be aware that a client's enrollment does not guarantee that the services provided will be reimbursed by BadgerCare Plus.

Topic #278

Persons Detained by Legal Process

Most individuals detained by legal process are *not* eligible for BadgerCare Plus or Wisconsin Medicaid benefits. Only those individuals who qualify for the [BadgerCare Plus Expansion for Certain Pregnant Women](#) may receive benefits.

"Detained by legal process" means a person who is incarcerated (including some Huber Law prisoners) because of law violation or alleged law violation, which includes misdemeanors, felonies, delinquent acts, and day-release prisoners. The justice system oversees health care-related needs for individuals detained by legal process who do not qualify for the BadgerCare Plus Expansion for Certain Pregnant Women.

Topic #280

Retroactive Enrollment

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

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

Reimbursing Members in Cases of Retroactive Enrollment

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

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

If a provider receives reimbursement from Medicaid for services provided to a retroactively enrolled member and the member has paid for the service, the provider is required to reimburse the member or authorized person acting on behalf of the member (e.g., local General Relief agency) the full amount that the member paid for the service.

If a claim cannot be filed within 365 days of the DOS (date of service) due to a delay in the determination of a member's retroactive enrollment, the provider is required to submit the claim to Timely Filing within 180 days of the date the retroactive enrollment is entered into Wisconsin's EVS (Enrollment Verification System) (if the services provided during the period of retroactive enrollment were covered).

Topic #546

Physician Services and Retroactive Coverage

Physician services providers should do the following when a member is granted retroactive enrollment and the service performed:

- *Required PA (prior authorization).* If a provider performed a service that required PA before the member was enrolled in Medicaid or BadgerCare Plus, the provider should request that the PA request be [backdated](#) to the DOS (date of service) and write "RETROACTIVE ENROLLMENT" on the [PA/RP \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#).
- *Was a sterilization procedure.* If the provider performed a [sterilization procedure](#) during a period of retroactive eligibility before the member was enrolled in Medicaid or BadgerCare Plus, and the provider has met all federal regulations including completing a required [Consent for Sterilization \(F-01164 \(10/08\)\)](#) form at least 30 days prior to the procedure, then a claim for the sterilization may be submitted to ForwardHealth for reimbursement.

If one or more of the federal requirements has not been met, including completing the consent form at least 30 days prior to the procedure, the sterilization service is considered not covered and the provider may not receive ForwardHealth reimbursement; however, the provider may bill the member. This policy applies to the sterilization procedure and any services related to the procedure.

To help facilitate reimbursement for sterilizations, it is recommended that providers use the Consent for Sterilization form before *all* sterilizations in the event that the applicant obtains Medicaid retroactive eligibility.

- *Was a hysterectomy procedure.* If the member underwent a [hysterectomy](#), the hysterectomy may be reimbursed if the provider attests in a signed statement uploaded via the Portal for electronically submitted claims or attached to a 1500 Health Insurance Claim Form that the member was, at a minimum:
 - Informed that the surgery would make her permanently incapable of reproducing.
 - Already sterile.
 - In a life-threatening situation that required a hysterectomy.

Topic #281

Spenddown to Meet Financial Enrollment Requirements

Occasionally, an individual with significant medical bills meets all enrollment requirements except those pertaining to income. These individuals are required to "spenddown" their income to meet financial enrollment requirements.

The certifying agency calculates the individual's spenddown (or deductible) amount, tracks all medical costs the individual incurs, and determines when the medical costs have satisfied the spenddown amount. (A payment for a medical service does not have to be made by the individual to be counted toward satisfying the spenddown amount.)

When the individual meets the spenddown amount, the certifying agency notifies ForwardHealth and the provider of the last service that the individual is eligible beginning on the date that the spenddown amount was satisfied.

If the individual's last medical bill is greater than the amount needed to satisfy the spenddown amount, the certifying agency notifies the affected provider by indicating the following:

- The individual is eligible for benefits as of the DOS (date of service) on the last bill.
- A claim for the service(s) on the last bill should be submitted to ForwardHealth. (The claim should indicate the full cost of the service.)
- The portion of the last bill that the individual must pay to the provider.

The certifying agency also informs ForwardHealth of the individual's enrollment and identifies the following:

- The DOS of the final charges counted toward satisfying the spenddown amount.

- The provider number of the provider of the last service.
- The spenddown amount remaining to be satisfied.

When the provider submits the claim, the spenddown amount will automatically be deducted from the provider's reimbursement for the claim. The spenddown amount is indicated in the Member's Share element on the [Medicaid Remaining Deductible Update \(F-10109 \(07/08\)\)](#) form sent to providers by the member's certifying agency. The provider's reimbursement is then reduced by the amount of the member's obligation.

Prior Authorization

7

Archive Date:01/02/2014

Prior Authorization:Advanced Imaging Services

Topic #15477

Exemption from Prior Authorization

Providers Ordering Computed Tomography and Magnetic Resonance Imaging Services

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

Note: It is the ordering provider's responsibility to communicate PA status (whether the provider is exempt from PA requirements or PA has been obtained through MedSolutions) to the rendering provider at the time of the request for advanced imaging services.

Exemption from Prior Authorization Requirements Not Available for Positron Emission Tomography

Decision support for PET (positron emission tomography) is not available in all advanced imaging decision support tools. Therefore, PET will not be eligible to be exempted from PA requirements at this time. ForwardHealth may review its policies and requirements in response to any future developments in decision support tools, including the addition of PET decision support tools to the PA exemption.

Process for Obtaining an Exemption from Prior Authorization Requirements

Requesting providers with advanced imaging decision support tools may request exemption from PA requirements for CT and MR imaging services using the following process:

1. Complete a [Prior Authorization Requirements Exemption Request for Computed Tomography \(CT\) and Magnetic Resonance \(MR\) Imaging Services \(F-00787 \(05/13\)\)](#) and agree to its terms.
2. Submit the completed Prior Authorization Requirements Exemption Request for CT and MR Imaging Services to the mailing or e-mail address listed on the form. Once received, ForwardHealth will review the exemption request materials, approve or deny the request, and send a decision letter to the requesting provider within 60 days after receipt of all necessary documentation. ForwardHealth will contact the requesting provider if any additional information is required for the application.
3. If the exemption request is approved, submit a list of all individual providers who order CT and MR scans using the requesting provider's decision support tool. Exemptions are verified using the NPI (National Provider Identifier) of the individual ordering provider; therefore, requesting providers should submit a complete list of all individual ordering providers within the requesting provider's group to ForwardHealth. Lists may be submitted via e-mail to DHSPAExemption@wisconsin.gov.

Process for Maintaining an Exemption from Prior Authorization

Requirements

To maintain exemption from PA requirements for advanced imaging services, the requesting provider is required to report the following outcome measures to ForwardHealth for the previous full six-month interval (January 1 through June 30 and July 1 through December 31) by July 31 and January 31 of each year:

- Aggregate score for all ordering providers that measures consistency with system recommendations based on the reporting standards described in more detail in Section III of the Prior Authorization Requirements Exemption Request for CT and MR Imaging Services form.
- Subset scores, grouped by primary and specialty care.
- Aggregate outcome measures identified in the quality improvement plan.

ForwardHealth will work with requesting providers to determine the most appropriate quality metrics. All requesting providers will need to provide similar data based on their reporting capabilities. This information should be submitted by the July 31 and January 31 deadlines to DHSPAExemption@wisconsin.gov.

Refer to the Prior Authorization Requirements Exemption Request for CT and MR Imaging Services form for more detailed information on quality improvement plans and maintaining exemption from PA requirements. Providers with questions regarding the requirements may e-mail them to DHSPAExemption@wisconsin.gov. If a requesting provider's quality improvement plan changes over time, any additional information identified in the plan must also be reported to this e-mail address.

ForwardHealth may discontinue an exemption after initial approval if it determines the requesting provider either no longer meets the requirements outlined previously or does not demonstrate meaningful use of decision support to minimize inappropriate utilization of CT and MR imaging services.

Updating the List of Eligible Providers

The requesting provider is required to maintain the list of individual ordering providers eligible for the exemption. The requesting provider will have two mechanisms for updating the list of individual ordering providers eligible for the exemption: individual entry of provider NPIs or uploading a larger, preformatted text file.

The requesting provider may enter individual NPIs using the Prior Authorization Exempted link under the Quick Links box in the secure Provider area of Portal.

For larger lists of providers eligible for exemption, requesting providers should upload a text file to the Portal that includes the individual provider NPIs, start dates for exemption, and end dates for exemption, if applicable. All submitted NPIs will be matched to the ForwardHealth provider file. ForwardHealth will notify the requesting provider monthly, using the e-mail contact indicated on the exemption application form, of any NPIs that cannot be matched.

ForwardHealth will enable the requesting provider's Portal administrator and delegated clerks to update the individual ordering providers for whom the exemption applies by July 1, 2013. Any changes that need to be made prior to that time for individual ordering providers eligible for the exemption should be sent to DHSPAExemption@wisconsin.gov.

The individual providers listed may order CT and MR imaging services without requesting PA for any DOS on and after the date the requesting provider indicates those providers are eligible to use the decision support tool, regardless of the date an individual provider's information was submitted to ForwardHealth.

For example, ABC Health Clinic is approved for an exemption from PA requirements on June 1. Dr. Smith of ABC Health Clinic orders an MR imaging service on June 15. It is discovered on June 20 that Dr. Smith was mistakenly excluded from ABC Health Clinic's exemption list. Once Dr. Smith is added to the exemption list, she is covered under the exemption going back to the date ABC Health Clinic indicated she was eligible to use the clinic's decision support tool.

Providers Rendering Advanced Imaging Services

Providers rendering advanced imaging services are encouraged to verify that either a PA request has been approved for the member (verified by contacting MedSolutions or the ordering provider), or the ordering provider is exempt from PA (verified by contacting the ordering provider) prior to rendering the service.

Claim Submission

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

Providers are also reminded to include the NPI of the ordering provider on the claim if the ordering provider is different from the rendering provider. If a PA request was not approved for the member and an exempt ordering provider's NPI is not included on the claim, the claim will be denied.

Topic #10678

Prior Authorization for Advanced Imaging Services

Most advanced imaging services, including CT (computed tomography), MR (magnetic resonance), and PET (positron emission tomography) imaging, require PA (prior authorization) when performed in either outpatient hospital settings or in non-hospital settings (e.g., radiology clinics). [MedSolutions](#), a private radiology benefits manager, is authorized to administer PA for advanced imaging services on behalf of ForwardHealth. Refer to the Prior Authorization section of the Radiology area of the Online Handbook for PA requirements and submission information for advanced imaging services.

Health systems, groups, and individual providers that order CT and MR imaging services and have implemented decision support tools may request an exemption from PA requirements for these services. Upon approval, ForwardHealth will recognize the requesting provider's advanced imaging decision support tool (e.g., ACR Select, Medicalis) as an alternative to current PA requirements for CT and MR imaging services.

Decisions

Topic #424

Approved Requests

PA (prior authorization) requests are approved for varying periods of time based on the clinical justification submitted. The provider receives a copy of a PA decision notice when a PA request for a service is approved. Providers may then begin providing the approved service on the grant date given.

An approved request means that the requested *service*, not necessarily the code, was approved. For example, a similar procedure code may be substituted for the originally requested procedure code. Providers are encouraged to review approved PA requests to confirm the services authorized and confirm the assigned grant and expiration dates.

Listing Procedure Codes Approved as a Group on the Decision Notice Letter

In certain circumstances, ForwardHealth will approve a PA request for a group of procedure codes with a total quantity approved for the entire group. When this occurs, the quantity approved for the entire group of codes will be indicated with the first procedure code. All of the other approved procedure codes within the group will indicate a quantity of zero.

Providers may submit claims for any combination of the procedure codes in the group up to the approved quantity.

Topic #4724

Communicating Prior Authorization Decisions

ForwardHealth will make a decision regarding a provider's PA (prior authorization) request within 20 working days from the receipt of all the necessary information. After processing the PA request, ForwardHealth will send the provider either a decision notice letter or a returned provider review letter. Providers will receive a decision notice letter for PA requests that were approved, approved with modifications, or denied. Providers will receive a returned provider review letter for PA requests that require corrections or additional information. The decision notice letter or returned provider review letter will clearly indicate what is approved or what correction or additional information ForwardHealth needs to continue adjudicating the PA request.

Providers submitting PA requests via the ForwardHealth Portal will receive a decision notice letter or returned provider review letter via the Portal.

If the provider submitted a PA request via [mail](#) or [fax](#) and the provider has a Portal account, the decision notice letter or returned provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper PA request via mail or fax and does not have a Portal account, the decision notice letter or returned provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), *not* to the address the provider wrote on the PA request.

The decision notice letter or returned provider review letter will not be faxed back to providers who submitted their paper PA request via fax. Providers who submitted their paper PA request via fax will receive the decision notice letter or returned provider letter via mail.

Topic #5038

Correcting Returned Prior Authorization Requests and Request Amendments on the Portal

If a provider received a returned provider review letter or an amendment provider review letter, he or she will be able to correct the errors identified on the returned provider review letter directly on the ForwardHealth Portal. Once the provider has corrected the error(s), the provider can resubmit the PA (prior authorization) request or amendment request via the Portal to ForwardHealth for processing. When correcting errors, providers only need to address the items identified in the returned provider review letter or the amendment provider review letter. Providers are not required to resubmit PA information already submitted to ForwardHealth.

Topic #5037

Decision Notice Letters and Returned Provider Review Letters on the Portal

Providers can view PA (prior authorization) decision notices and provider review letters via the secure area of the ForwardHealth Portal. Prior authorization decision notices and provider review letters can be viewed when the PA is selected on the Portal.

Note: The PA decision notice or the provider review letter will not be available until the day after the PA request is processed by ForwardHealth.

Topic #425

Denied Requests

When a PA (prior authorization) request is denied, both the provider and the member are notified. The provider receives a PA decision notice, including the reason for PA denial. The member receives a [Notice of Appeal Rights](#) letter that includes a brief statement of the reason PA was denied and information about his or her right to a fair hearing. Only the *member, or authorized person acting on behalf of the member*, can appeal the denial.

Providers may call [Provider Services](#) for clarification of why a PA request was denied.

Providers are required to discuss a denied PA request with the member and are encouraged to help the member understand the reason the PA request was denied.

Providers have three options when a PA request is denied:

- Not provide the service.
- Submit a *new* PA request. Providers are required to submit a copy of the original denied PA request and additional supporting clinical documentation and medical justification along with a new [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#), [PA/DRF \(Prior Authorization/Dental Request Form, F-11035 \(07/12\)\)](#), or [PA/HIAS1 \(Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 \(05/13\)\)](#).
- Provide the service as a noncovered service.

If the member does not appeal the decision to deny the PA request or appeals the decision but the decision is upheld and the member chooses to receive the service anyway, the member may choose to receive the service(s) as a [noncovered service](#).

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
 <sequence number>
 <RecipName> Member Identification Number:
 <RecipAddressLine1> <XXX-XX-XXXXXX>
 <RecipAddressLine2> Local County or Tribal Agency
 <RecipCity> <RecipStateZip> Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXX.XX	XXXXXX.XX
XXXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXX.XX	XXXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

- 1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.
- 2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

Division of Hearings and Appeals
 Department of Administration
 PO Box 7875
 Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #426

Modified Requests

Modification is a change in the services originally requested on a PA (prior authorization) request. Modifications could include, but are not limited to, either of the following:

- The authorization of a procedure code different than the one originally requested.
- A change in the frequency or intensity of the service requested.

When a PA request is modified, both the provider and the member are notified. The provider will be sent a decision notice letter. The decision notice letter will clearly indicate what is approved or what correction or additional information is needed to continue adjudicating the PA request. The member receives a [Notice of Appeal Rights](#) letter that includes a brief statement of the reason PA was modified and information on his or her right to a fair hearing. Only the *member, or authorized person acting on behalf of the member*, can appeal the modification.

Providers are required to discuss with the member the reasons a PA request was modified.

Providers have the following options when a PA request is approved with modification:

- Provide the service as authorized.
- Submit a request to amend the modified PA request. Additional supporting clinical documentation and medical justification must be included.
- Not provide the service.
- Provide the service as originally requested as a noncovered service.

If the member does not appeal the decision to modify the PA request or appeals the decision but the decision is upheld and the member chooses to receive the originally requested service anyway, the member may choose to receive the service(s) as a [noncovered service](#).

Providers may call [Provider Services](#) for clarification of why a PA request was modified.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
 <sequence number>
 <RecipName>
 <RecipAddressLine1>
 <RecipAddressLine2>
 <RecipCity> <RecipStateZip>

Member Identification Number:
 <XXX-XX-XXXXXX>
 Local County or Tribal Agency
 Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
<DeniedServiceNN>				

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
<ModifiedServiceNN>				

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

- 1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.
- 2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

Division of Hearings and Appeals
Department of Administration
PO Box 7875
Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #4737

Returned Provider Review Letter Response Time

Thirty Days to Respond to the Returned Provider Review Letter

ForwardHealth must receive the provider's response within 30 calendar days of the date on the returned provider review letter, whether the letter was sent to the provider by mail or through the ForwardHealth Portal. If the provider's response is received within 30 calendar days, ForwardHealth still considers the original receipt date on the PA (prior authorization) request when authorizing a grant date for the PA.

If ForwardHealth does not receive the provider's response within 30 calendar days of the date the returned provider review letter was sent, the PA status becomes inactive and the provider is required to submit a new PA request. This results in a later grant date if the PA request is approved. Providers will not be notified when their PA request status changes to inactive, but this information will be available on the Portal and through [WiCall](#).

If ForwardHealth receives additional information from the provider after the 30-day deadline has passed, a letter will be sent to the provider stating that the PA request is inactive and the provider is required to submit a new PA request.

Topic #427

Returned Requests

A PA (prior authorization) request may be returned to the provider when forms are incomplete, inaccurate, or additional clinical information or corrections are needed. When this occurs, the provider will be sent a provider review letter.

Returned Provider Review Letter

The returned provider review letter will indicate the PA number assigned to the request and will specify corrections or additional information needed on the PA request. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct PAs that have been placed in returned provider review status in the ForwardHealth Portal.

The provider's paper documents submitted with the PA request will not be returned to the provider when corrections or additional information are needed; however, X-rays and dental models will be returned once the PA is finalized.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

Therefore, providers are required to make a copy of their PA requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if more information is required about the PA request.

Note: When changing or correcting the PA request, providers are reminded to revise or update the documentation retained in their records.

Emergent and Urgent Situations

Topic #429

Emergency Services

In emergency situations, the PA (prior authorization) requirement may be waived for services that normally require PA. Emergency services are defined in [DHS 101.03\(52\)](#), Wis. Admin. Code, as "those services which are necessary to prevent the death or serious impairment of the health of the individual."

Reimbursement is not guaranteed for services that normally require PA that are provided in emergency situations. As with all covered services, emergency services must meet all [program requirements](#), including medical necessity, to be reimbursed by Wisconsin Medicaid. For example, reimbursement is contingent on, but not limited to, eligibility of the member, the circumstances of the emergency, and the medical necessity of the services provided.

Wisconsin Medicaid will not reimburse providers for noncovered services provided in any situation, including emergency situations.

Topic #430

Urgent Services

Telephone consultations with DHCAA (Division of Health Care Access and Accountability) staff regarding a prospective PA (prior authorization) request can be given only in urgent situations when medically necessary. An urgent, medically necessary situation is one where a delay in authorization would result in undue hardship for the member or unnecessary costs for Medicaid as determined by the DHCAA. All telephone consultations for urgent services should be directed to the Quality Assurance and Appropriateness Review Section at (608) 266-2521. Providers should have the following information ready when calling:

- Member's name.
- Member identification number.
- Service(s) needed.
- Reason for the urgency.
- Diagnosis of the member.
- Procedure code of the service(s) requested.

Providers are required to submit a PA request to ForwardHealth within 14 calendar days after the date of the telephone consultation. PA may be denied if the request is received more than two weeks after the consultation. If the PA request is denied in this case, the provider cannot request payment from the member.

Follow-Up to Decisions

Topic #4738

Amendment Decisions

ForwardHealth will make a decision regarding a provider's amendment request within 20 working days from the receipt of all the information necessary. The method ForwardHealth will use to communicate decisions regarding PA (prior authorization) amendment requests will depend on how the *PA request* was originally submitted (not how the amendment request was submitted) and whether the provider has a ForwardHealth Portal account:

- If the PA request was originally submitted via the Portal, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal.
- If the PA request was originally submitted via mail or fax and the provider has a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal, as well as by mail.
- If the PA request was originally submitted via mail or fax and the provider does *not* have a Portal account, the decision notice letter or returned amendment provider review letter will be sent by mail to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), *not* to the address the provider wrote on the PA request or amendment request.

Topic #431

Amendments

Providers are required to use the [Prior Authorization Amendment Request \(F-11042 \(07/12\)\)](#) to amend an approved or modified PA (prior authorization) request.

ForwardHealth does not accept a paper amendment request submitted on anything other than the Prior Authorization Amendment Request. The Prior Authorization Amendment Request may be submitted through the ForwardHealth Portal as well as by [mail](#) or [fax](#). If ForwardHealth receives a PA amendment on a previous version of the Prior Authorization Amendment Request form, a letter will be sent to the provider stating that the provider is required to submit a new PA amendment request using the proper forms.

Examples of when providers may request an amendment to an approved or modified PA request include the following:

- To temporarily modify a member's frequency of a service when there is a short-term change in his or her medical condition.
- To change the rendering provider information when the billing provider remains the same.
- To change the member's ForwardHealth identification number.
- To add or change a procedure code.

Note: ForwardHealth recommends that, under most circumstances, providers should enddate the current PA request and submit a new one if there is a significant, long-term change in services required.

Topic #432

Appeals

If a PA (prior authorization) request is denied or modified by ForwardHealth, only a member, or authorized person acting on behalf of the member, may file an appeal with the DHA (Division of Hearings and Appeals). Decisions that may be appealed include the following:

- Denial or modification of a PA request.
- Denial of a retroactive authorization for a service.

The member is required to file an appeal within 45 days of the date of the [Notice of Appeal Rights](#).

To file an appeal, members may complete and submit a [Request for Fair Hearing \(DHA-28 \(08/09\)\)](#) form.

Though providers cannot file an appeal, they are encouraged to remain in contact with the member during the appeal process. Providers may offer the member information necessary to file an appeal and help present his or her case during a fair hearing.

Fair Hearing Upholds ForwardHealth's Decision

If the hearing decision upholds the decision to deny or modify a PA request, the DHA notifies the member and ForwardHealth in writing. The member may choose to receive the service (or in the case of a modified PA request, the originally requested service) as a noncovered service, not receive the service at all, or appeal the decision.

Fair Hearing Overturns ForwardHealth's Decision

If the hearing decision overturns the decision to deny or modify the PA request, the DHA notifies ForwardHealth and the member. The letter includes instructions for the provider and for ForwardHealth.

If the DHA letter instructs the provider(s) to submit a claim for the service, each provider should submit the following to ForwardHealth after the service(s) has been performed:

- A paper claim with "HEARING DECISION ATTACHED" written in red ink at the top of the claim.
- A copy of the hearing decision.
- A copy of the denied PA request.

Providers are required to submit claims with hearing decisions to the following address:

ForwardHealth
Specialized Research
Ste 50
313 Blettner Blvd
Madison WI 53784

Claims with hearing decisions sent to any other address may not be processed appropriately.

If the DHA letter instructs the provider to submit a new PA request, the provider is required to submit the *new* PA request along with a copy of the hearing decision to the PA Unit at the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

ForwardHealth will then approve the PA request with the revised process date. The provider may then submit a claim following

the usual claims submission procedures after providing the service(s).

Financial Responsibility

If the member asks to receive the service *before* the hearing decision is made, the provider is required to notify the member before rendering the service that the member will be responsible for payment if the decision to deny or modify the PA request is upheld.

If the member accepts responsibility for payment of the service before the hearing decision is made, and if the appeal decision *upholds* the decision to deny or modify the PA request, the provider [may collect payment from the member](#) if certain conditions are met.

If the member accepts responsibility for payment of the service before the hearing decision is made, and if the appeal decision *overturns* the decision to deny or modify a PA request, the provider may submit a claim to ForwardHealth. If the provider collects payment from the member for the service before the appeal decision is overturned, the provider is required to refund the member for the *entire* amount of payment received from the member after the provider receives Medicaid's reimbursement.

Wisconsin Medicaid does not directly reimburse members.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
 <sequence number>
 <RecipName>
 <RecipAddressLine1>
 <RecipAddressLine2>
 <RecipCity> <RecipStateZip>

Member Identification Number:
 <XXX-XX-XXXXXX>
 Local County or Tribal Agency
 Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

- 1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.
- 2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

Division of Hearings and Appeals
Department of Administration
PO Box 7875
Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #1106

Enddating

Providers are required to use the [Prior Authorization Amendment Request \(F-11042 \(07/12\)\)](#) to enddate most PA (prior authorization) requests. ForwardHealth does not accept requests to enddate a PA request for any service, except drugs, on anything other than the Prior Authorization Amendment Request. PA for drugs may be enddated by using STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) in addition to submitting a Prior Authorization Amendment Request.

Providers may submit a Prior Authorization Amendment Request on the ForwardHealth Portal, or by fax or mail.

If a request to enddate a PA is not submitted on the Prior Authorization Amendment Request, a letter will be sent to the provider stating that the provider is required to submit the request using the proper forms.

Examples of when a PA request should be enddated include the following:

- A member chooses to discontinue receiving prior authorized services.
- A provider chooses to discontinue delivering prior authorized services.

Examples of when a PA request should be enddated and a new PA request should be submitted include the following:

- There is an interruption in a member's continual care services.
- There is a change in the member's condition that warrants a long-term change in services required.
- The service(s) is no longer medically necessary.

Topic #4739

Returned Amendment Provider Review Letter

If the amendment request needs correction or additional information, a returned amendment provider review letter will be sent. The letter will show how the PA (prior authorization) appears currently in the system and providers are required to respond by correcting errors identified on the letter. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct an amendment request that has been placed in returned provider review status in the ForwardHealth Portal.

ForwardHealth must receive the provider's response within 30 calendar days of the date the returned amendment provider review letter was sent. After 30 days the amendment request status becomes inactive and the provider is required to submit a new

amendment request. The ForwardHealth interChange system will continue to use the original approved PA request for processing claims.

The provider's paper documents submitted with the amendment request will not be returned to the provider when corrections or additional information are needed; however, X-rays and dental models will be returned once the amendment request is finalized.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

Therefore, providers are required to make a copy of their amendment requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the amendment request.

Note: When changing or correcting the amendment request, providers are reminded to revise or update the documentation retained in their records.

Topic #5039

Searching for Previously Submitted Prior Authorization Requests on the Portal

Providers will be able to search for all previously submitted PA (prior authorization) requests, regardless of how the PA was initially submitted. If the provider knows the PA number, he or she can enter the number to retrieve the PA information. If the provider does not know the PA number, he or she can search for a PA by entering information in one or more of the following fields:

- Member identification number.
- Requested start date.
- Prior authorization status.
- Amendment status.

If the provider does not search by any of the information above, providers will retrieve all their PA requests submitted to ForwardHealth.

Forms and Attachments

Topic #960

An Overview

Depending on the service being requested, most PA (prior authorization) requests must be comprised of the following:

- The [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#), [PA/DRF \(Prior Authorization/Dental Request Form, F-11035 \(07/12\)\)](#), or [PA/HIAS1 \(Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 \(05/13\)\)](#).
- A service-specific PA attachment(s).
- Additional supporting clinical documentation.

Topic #446

Attachments

In addition to the [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#), [PA/HIAS1 \(Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 \(05/13\)\)](#), or [PA/DRF \(Prior Authorization/Dental Request Form, F-11035 \(07/12\)\)](#), a service-specific PA (prior authorization) attachment must be submitted with each PA request. The PA attachment allows a provider to document the clinical information used to determine whether or not the standards of medical necessity are met for the requested service(s). Providers should include adequate information for ForwardHealth to make a reasonable judgment about the case.

ForwardHealth will scan each form with a barcode as it is received, which will allow greater efficiencies for processing PA requests.

Topic #527

Prior Authorization/Physician Attachment

The [PA/PA \(Prior Authorization/Physician Attachment, F-11016 \(07/12\)\)](#) allows a provider to document the clinical information used to determine whether the standards of medical necessity are met for the requested service(s). Physician services providers should use the PA/PA for most services requiring PA.

Prior Authorization/"J" Code Attachment

The purpose of the [PA/JCA \(Prior Authorization/"J" Code Attachment, F-11034 \(07/12\)\)](#) is to document the medical necessity of physician-administered drugs requiring PA.

Prior Authorization/Physician Otological Report

Completion of the [PA/POR \(Prior Authorization/Physician Otological Report, F-11019 \(07/12\)\)](#) begins the process by which PA is obtained for a hearing aid by a hearing instrument specialist. The physician gives page one (or a copy) of the completed PA/POR to the member and keeps page two (or a copy of it) in the member's medical records. The member then takes the PA/POR to any Medicaid-enrolled hearing instrument specialist to receive a hearing aid.

Topic #447

Obtaining Forms and Attachments

Providers may obtain paper versions of all PA (prior authorization) forms and attachments. In addition, providers may download and complete most PA attachments from the [ForwardHealth Portal](#).

Paper Forms

Paper versions of all PA forms and PA attachments are available by writing to ForwardHealth. Include a return address, the name of the form, the form number (if applicable), and mail the request to the following address:

ForwardHealth
Form Reorder
313 Blettner Blvd
Madison WI 53784

Providers may also call [Provider Services](#) to order paper copies of forms.

Downloadable Forms

Most PA attachments can be downloaded and printed in their original format from the Portal. Many forms are available in fillable PDF (Portable Document Format) and fillable Microsoft® Word formats.

Web Prior Authorization Via the Portal

Certain providers may complete the [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#) and PA attachments through the Portal. Providers may then print the PA/RF (and in some cases the PA attachment), and send the PA/RF, service-specific PA attachments, and any supporting documentation on paper by mail or fax to ForwardHealth.

Topic #448

Prior Authorization Request Form

The [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#) is used by ForwardHealth and is mandatory for most providers when requesting PA (prior authorization). The PA/RF serves as the cover page of a PA request.

Providers are required to complete the basic provider, member, and service information on the PA/RF. Each PA request is assigned a unique ten-digit number. ForwardHealth remittance information will report to the provider the PA number used to process the claim for prior authorized services.

Topic #4677

Prior Authorization Request Form Completion Instructions for Physician Services

A [sample PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#) for physician services is available.

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number ([DHS 104.02\[4\]](#), Wis. Admin. Code).

Under s. [49.45\(4\)](#), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing PA (prior authorization) requests, or processing provider claims for reimbursement. The use of the PA/RF is mandatory to receive PA for certain items. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests, along with all applicable service-specific attachments, including the [PA/PA \(Prior Authorization/Physician Attachment, F-11016 \(07/12\)\)](#), the [PA/JCA \(Prior Authorization/"J" Code Attachment, F-11034 \(07/12\)\)](#), and the [Prior Authorization Drug Attachment for Synagis \(F-00142 \(10/09\)\)](#) by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — HealthCheck "Other Services" and Wisconsin Chronic Disease Program (WCDP)

Enter an "X" in the box next to HealthCheck "Other Services" if the services requested on the PA/RF are for HealthCheck "Other Services." Enter an "X" in the box next to WCDP (Wisconsin Chronic Disease Program) if the services requested on the PA/RF are for a WCDP member.

Element 2 — Process Type

Enter processing type "117" to indicate physician services, including family planning clinics, rural health clinics, and federally qualified health centers. The processing type is a three-digit code used to identify a category of service requested. Prior authorization requests will be returned without adjudication if no processing type is indicated.

Element 3 — Telephone Number — Billing Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 4 — Name and Address — Billing Provider

Enter the name and complete address (street, city, state, and ZIP+4 code) of the billing provider. Providers are required to include both the ZIP code and four-digit extension for timely and accurate billing. The name listed in this element must correspond with the billing provider number listed in Element 5a.

Element 5a — Billing Provider Number

Enter the NPI (National Provider Identifier) of the billing provider. The NPI in this element must correspond with the provider name listed in Element 4.

Element 5b — Billing Provider Taxonomy Code

Enter the national 10-digit alphanumeric taxonomy code that corresponds to the NPI of the billing provider in Element 5a.

Element 6a — Name — Prescribing / Referring / Ordering Provider (not required)**Element 6b — National Provider Identifier — Prescribing / Referring / Ordering Provider (not required)****SECTION II — MEMBER INFORMATION****Element 7 — Member Identification Number**

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or Wisconsin's EVS (Enrollment Verification System) to obtain the correct number.

Element 8 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

Element 9 — Address — Member

Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code. If the member is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 10 — Name — Member

Enter the member's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 11 — Gender — Member

Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION**Element 12 — Diagnosis — Primary Code and Description**

Enter the appropriate ICD-9-CM (*International Classification of Diseases, Ninth Revision, Clinical Modification*) diagnosis code and description most relevant to the service/procedure requested.

Element 13 — Start Date — SOI (not required)**Element 14 — First Date of Treatment — SOI (not required)****Element 15 — Diagnosis — Secondary Code and Description**

Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Element 16 — Requested PA Start Date

Enter the requested start date for service(s) in MM/DD/CCYY format, if a specific start date is requested.

Element 17 — Rendering Provider Number

Enter the NPI of the provider who will be performing the service or prescribing the drug, only if the NPI is different from the NPI of the billing provider listed in Element 5a.

Element 18 — Rendering Provider Taxonomy Code

Enter the national 10-digit alphanumeric taxonomy code that corresponds to the provider who will be performing the service or prescribing the drug, only if this code is different from the taxonomy code listed for the billing provider in Element 5b.

Element 19 — Service Code

Enter the appropriate CPT (*Current Procedural Terminology*) code or HCPCS (Healthcare Common Procedure Coding System) code for each service/procedure/item requested.

Element 20 — Modifiers

Enter the modifier(s) corresponding to the procedure code listed if a modifier is required.

Element 21 — POS

Enter the appropriate POS (place of service) code designating where the requested service/procedure/item would be provided/performed/dispensed.

Element 22 — Description of Service

Enter a written description corresponding to the appropriate CPT code or HCPCS code for each service/procedure/item requested.

Element 23 — QR

Enter the appropriate quantity (e.g., number of services, days' supply) requested for the procedure code listed.

Element 24 — Charge

Enter the provider's usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to provider *Terms of Reimbursement* issued by the DHS.

Element 25 — Total Charges

Enter the anticipated total charges for this request.

Element 26 — Signature — Requesting Provider

The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 27 — Date Signed

Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

Sample PA/RF for Physician Services

DEPARTMENT OF HEALTH SERVICES
ForwardHealth
F-11018 (05/13)

STATE OF WISCONSIN
DHS 106.03(4), Wis. Admin. Code
DHS 152.06(3)(h), 153.06(3)(a), 154.06(3)(a), Wis. Admin. Code

**FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)**

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable <input type="checkbox"/> HealthCheck "Other Services" <input type="checkbox"/> Wisconsin Chronic Disease Program (WCDP)	2. Process Type 117	3. Telephone Number — Billing Provider (555) 555-5555
4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code) I.M. BILLING PROVIDER 609 WILLOW ST ANYTOWN WI 55555-1234		5a. Billing Provider Number 0222222220
		5b. Billing Provider Taxonomy Code 123456789X
6a. Name — Prescribing / Referring / Ordering Provider		6b. National Provider Identifier — Prescribing / Referring / Ordering Provider

SECTION II — MEMBER INFORMATION

7. Member Identification Number 1234567890	8. Date of Birth — Member MM/DD/CCYY	9. Address — Member (Street, City, State, ZIP Code) 322 RIDGE ST ANYTOWN WI 55555
10. Name — Member (Last, First, Middle Initial) MEMBER, IM A		11. Gender — Member <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

12. Diagnosis — Primary Code and Description 611.1 — Hypertrophy of breast								13. Start Date — SOI		14. First Date of Treatment — SOI	
15. Diagnosis — Secondary Code and Description 709.9 — Dermatosi NOS								16. Requested PA Start Date			
17. Rendering Provider Number	18. Rendering Provider Taxonomy Code	19. Service Code	20. Modifiers				21. POS	22. Description of Service	23. QR	24. Charge	
			1	2	3	4					
0222222220	123456789X	19318	50				21	Reduction mammoplasty	1	XXX.XX	
An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.									25. Total Charges	XXX.XX	
26. SIGNATURE — Requesting Provider <i>I.M. Requesting Provider</i>									27. Date Signed MM/DD/CCYY		

Topic #7797

Prior Authorization Request Form Completion Instructions for Prescribers for Drugs

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number ([DHS 104.02\[4\]](#), Wis. Admin. Code).

Under s. [49.45\(4\)](#), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing PA (prior authorization) requests, or processing provider claims for reimbursement. The use of this form is mandatory to receive PA of certain procedures/services/items. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests, along with all applicable service-specific attachments, via the ForwardHealth Portal, by fax to ForwardHealth at (608) 221-8616, or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — HealthCheck "Other Services" and Wisconsin Chronic Disease Program (WCDP)

Leave the box next to HealthCheck "Other Services" blank. Enter an "X" in the box next to WCDP (Wisconsin Chronic Disease Program) if the services requested on the [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#) are for a WCDP member.

Element 2 — Process Type

Enter process type 117 — Physician Services. The process type is a three-digit code used to identify a category of service requested. PA requests will be returned without adjudication if no process type is indicated.

Element 3 — Telephone Number — Billing Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 4 — Name and Address — Billing Provider

Enter the name and complete address (street, city, state, and ZIP+4 code) of the billing provider. Providers are required to include both the ZIP code and four-digit extension for timely and accurate billing. The name listed in this element must correspond with the billing provider number listed in Element 5a.

Element 5a — Billing Provider Number

Enter the NPI (National Provider Identifier) of the billing provider. The NPI in this element must correspond with the provider name listed in Element 4.

Element 5b — Billing Provider Taxonomy Code

Enter the national 10-digit alphanumeric taxonomy code that corresponds to the NPI of the billing provider in Element 5a.

Element 6a — Name — Prescribing / Referring / Ordering Provider

Enter the prescribing/referring/ordering provider's name.

Element 6b — National Provider Identifier — Prescribing / Referring / Ordering Provider

Enter the prescribing/referring/ordering provider's 10-digit NPI.

SECTION II — MEMBER INFORMATION

Element 7 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or Wisconsin's EVS (Enrollment Verification System) to obtain the correct number.

Element 8 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

Element 9 — Address — Member

Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code. If the member is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 10 — Name — Member

Enter the member's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 11 — Gender — Member

Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 12 — Diagnosis — Primary Code and Description

Enter the appropriate ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis code and description most relevant to the service/procedure requested.

Element 13 — Start Date — SOI (not required)

Element 14 — First Date of Treatment — SOI (not required)

Element 15 — Diagnosis — Secondary Code and Description

Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Element 16 — Requested PA Start Date

Enter the requested start DOS (date of service) in MM/DD/CCYY format.

Element 17 — Rendering Provider Number

Enter the prescriber's NPI, only if the NPI is different from the NPI of the billing provider listed in Element 5a.

Element 18 — Rendering Provider Taxonomy Code

Enter the national 10-digit alphanumeric taxonomy code that corresponds to the prescriber only if this code is different from the taxonomy code listed for the billing provider in Element 5b.

Element 19 — Service Code (not required)

Element 20 — Modifiers (not required)

Element 21 — POS

Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

Element 22 — Description of Service

Enter the drug name and dose for each item requested (e.g., drug name, milligrams, capsules).

Element 23 — QR

Enter the appropriate quantity (e.g., days' supply) requested for each item requested.

Element 24 — Charge (not required)**Element 25 — Total Charges (not required)****Element 26 — Signature — Requesting Provider**

The original signature of the provider requesting this item must appear in this element.

Element 27 — Date Signed

Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

Topic #449

Supporting Clinical Documentation

Certain PA (prior authorization) requests may require additional supporting clinical documentation to justify the medical necessity for a service(s). Supporting documentation may include, but is not limited to, X-rays, photographs, a physician's prescription, clinical reports, and other materials related to the member's condition.

All supporting documentation submitted with a PA request must be clearly labeled and identified with the member's name and member identification number. Securely packaged X-rays and dental models will be returned to providers.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

General Information

Topic #4402

An Overview

The PA (prior authorization) review process includes both a clerical review and a clinical review. The PA request will have one of the statuses detailed in the following table.

Prior Authorization Status	Description
Approved	The PA request was approved.
Approved with Modifications	The PA request was approved with modifications to what was requested.
Denied	The PA request was denied.
Returned — Provider Review	The PA request was returned to the provider for correction or for additional information.
Pending — Fiscal Agent Review	The PA request is being reviewed by the Fiscal Agent.
Pending — Dental Follow-up	The PA request is being reviewed by a Fiscal Agent dental specialist.
Pending — State Review	The PA request is being reviewed by the State.
Suspend — Provider Sending Information	The PA request was submitted via the ForwardHealth Portal and the provider indicated they will be sending additional supporting information on paper.
Inactive	The PA request is inactive due to no response within 30 days to the returned provider review letter and cannot be used for PA or claims processing.

Topic #434

Communication with Members

ForwardHealth recommends that providers inform members that PA (prior authorization) is required for certain specified services *before* delivery of the services. Providers should also explain that, if required to obtain PA, they will be submitting member records and information to ForwardHealth on the member's behalf. Providers are required to keep members informed of the PA request status throughout the *entire* PA process.

Member Questions

A member may call [Member Services](#) to find out whether or not a PA request has been submitted and, if so, when it was received by ForwardHealth. The member will be advised to contact the provider if more information is needed about the status of an individual PA request.

Topic #435

Definition

PA (prior authorization) is the electronic or written authorization issued by ForwardHealth to a provider prior to the provision of a service. In most cases, providers are required to obtain PA *before* providing services that require PA. When granted, a PA

request is approved for a specific period of time and specifies the type and quantity of service allowed.

Topic #5098

Designating an Address for Prior Authorization Correspondence

Correspondence related to PA (prior authorization) will be sent to the practice location address on file with ForwardHealth unless the provider designates a separate address for receipt of PA correspondence. This policy applies to all PA correspondence, including decision notice letters, returned provider review letters, returned amendment provider letters, and returned supplemental documentation such as X-rays and dental models.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

Providers may designate a separate address for PA correspondence using the demographic maintenance tool, which can be accessed through their secure ForwardHealth Portal account.

Topic #4383

Prior Authorization Numbers

Upon receipt of the [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#), ForwardHealth will assign a PA (prior authorization) number to each PA request.

The PA number consists of 10 digits, containing valuable information about the PA (e.g., the date the PA request was received by ForwardHealth, the medium used to submit the PA request).

Each PA request is assigned a unique PA number. This number identifies valuable information about the PA. The following table provides detailed information about interpreting the PA number.

Type of Number and Description	Applicable Numbers and Description
Media — One digit indicates media type.	Digits are identified as follows: 1= paper; 2 = fax; 3 = STAT-PA (Specialized Transmission Approval Technology-Prior Authorization); 4 = STAT-PA; 5 = Portal; 6 = Portal; 7 = NCPDP (National Council for Prescription Drug Programs) transaction or 278 (278 Health Care Services Review - Request for Review and Response) transaction; 9 = MedSolutions
Year — Two digits indicate the year ForwardHealth received the PA request.	For example, the year 2008 would appear as 08.
Julian date — Three digits indicate the day of the year, by Julian date, that ForwardHealth received the PA request.	For example, February 3 would appear as 034.
Sequence number — Four digits indicate the sequence number.	The sequence number is used internally by ForwardHealth.

Topic #436

Reasons for Prior Authorization

Only about four percent of all services covered by Wisconsin Medicaid require PA (prior authorization). PA requirements vary for different types of services. Refer to ForwardHealth publications and [DHS 107](#), Wis. Admin. Code, for information regarding services that require PA. According to [DHS 107.02\(3\)\(b\)](#), Wis. Admin. Code, PA is designed to do the following:

- Safeguard against unnecessary or inappropriate care and services.
- Safeguard against excess payments.
- Assess the quality and timeliness of services.
- Promote the most effective and appropriate use of available services and facilities.
- Determine if less expensive alternative care, services, or supplies are permissible.
- Curtail misutilization practices of providers and members.

PA requests are processed based on criteria established by the DHS (Department of Health Services).

Providers should not request PA for services that do not require PA simply to determine coverage or establish a reimbursement rate for a manually priced procedure code. Also, new technologies or procedures do not necessarily require PA. PA requests for services that do not require PA are typically returned to the provider. Providers having difficulties determining whether or not a service requires PA may call [Provider Services](#).

Topic #437

Referrals to Out-of-State Providers

PA (prior authorization) may be granted to out-of-state providers when nonemergency services are necessary to help a member attain or regain his or her health and ability to function independently. The PA request may be approved only when the services are not reasonably accessible to the member in Wisconsin.

Out-of-state providers are required to meet ForwardHealth's guidelines for PA approval. This includes sending PA requests, required attachments, and supporting documentation to ForwardHealth before the services are provided.

Note: Emergency services provided out-of-state do not require PA; however, claims for such services must include appropriate documentation (e.g., anesthesia report, medical record) to be considered for reimbursement. Providers are required to submit claims with supporting documentation on paper.

When a Wisconsin Medicaid provider refers a member to an out-of-state provider, the referring provider should instruct the out-of-state provider to go to the [Provider Enrollment Information home page](#) on the ForwardHealth Portal to complete a Medicaid Out-of-State Provider Enrollment Application.

All out-of-state nursing homes, regardless of location, are required to obtain PA for all services. All other out-of-state non-border-status providers are required to obtain PA for all nonemergency services except for home dialysis supplies and equipment.

Topic #438

Reimbursement Not Guaranteed

Wisconsin Medicaid may decline to reimburse a provider for a service that has been prior authorized if one or more of the following program requirements is not met:

- The service authorized on the approved PA (prior authorization) request is the service provided.

- The service is provided within the grant and expiration dates on the approved PA request.
- The member is eligible for the service on the date the service is provided.
- The provider is enrolled in Wisconsin Medicaid on the date the service is provided.
- The service is billed according to service-specific claim instructions.
- The provider meets other program requirements.

Providers may not [collect payment](#) from a member for a service requiring PA under any of the following circumstances:

- The provider failed to seek PA before the service was provided.
- The service was provided before the PA grant date or after the PA expiration date.
- The provider obtained PA but failed to meet other program requirements.
- The service was provided before a decision was made, the member did not accept responsibility for the payment of the service before the service was provided, and the PA was denied.

There are [certain situations](#) when a provider may collect payment for services in which PA was denied.

Other Health Insurance Sources

Providers are encouraged, but not required, to request PA from ForwardHealth for covered services that require PA when members have other health insurance coverage. This is to allow payment by Wisconsin Medicaid for the services provided in the event that the other health insurance source denies or recoups payment for the service. If a service is provided before PA is obtained, ForwardHealth will not consider backdating a PA request solely to enable the provider to be reimbursed.

Topic #1268

Sources of Information

Providers should verify that they have the most current sources of information regarding PA (prior authorization). It is critical that providers and staff have access to these documents:

- Wisconsin Administrative Code: Chapters [DHS 101 through DHS 109](#) are the rules regarding Medicaid administration.
- Wisconsin Statutes: Sections [49.43 through 49.99](#) provide the legal framework for Wisconsin Medicaid.
- ForwardHealth Portal: The Portal gives the latest policy information for all providers, including information about Medicaid managed care enrollees.

Topic #812

Status Inquiries

Providers may inquire about the status of a PA (prior authorization) request through one of the following methods:

- Accessing [WiCall](#), ForwardHealth's AVR (Automated Voice Response) system.
- Calling [Provider Services](#).

Providers should have the 10-digit PA number available when making inquiries.

Topic #13697

Third-Party Web Sites

The ForwardHealth Portal allows providers access to all policy and billing information for BadgerCare Plus, Medicaid, SeniorCare, ADAP (Wisconsin AIDS Drug Assistance Program), and WCDP (Wisconsin Chronic Disease Program) in one centralized place. PA (prior authorization) request forms and information about ForwardHealth's policies should be obtained from the Portal or [Provider Services](#). Third-party Web sites are not affiliated with or endorsed by ForwardHealth.

Grant and Expiration Dates

Topic #439

Backdating

Backdating an initial PA (prior authorization) request or SOI (spell of illness) to a date prior to ForwardHealth's initial receipt of the request may be allowed in limited circumstances.

A request for backdating may be approved if all of the following conditions are met:

- The provider specifically requests backdating in writing on the PA or SOI request.
- The request includes clinical justification for beginning the service before PA or SOI was granted.
- The request is received by ForwardHealth within 14 calendar days of the start of the provision of services.

Topic #440

Expiration Date

The expiration (end) date of an approved or modified PA (prior authorization) request is the date through which services are prior authorized. PA requests are granted for varying periods of time. Expiration dates may vary and do not automatically expire at the end of the month or calendar year. In addition, providers may request a specific expiration date. Providers should carefully review all approved and modified PA requests and make note of the expiration dates.

Topic #441

Grant Date

The grant (start) date of an approved or modified PA (prior authorization) request is the first date in which services are prior authorized and will be reimbursed under this PA number. On a PA request, providers may request a specific date that they intend services to begin. If no grant date is requested or the grant date is illegible, the grant date will typically be the date the PA request was reviewed by ForwardHealth.

Topic #442

Renewal Requests

To prevent a lapse in coverage or reimbursement for ongoing services, all renewal PA (prior authorization) requests (i.e., subsequent PA requests for ongoing services) must be received by ForwardHealth *prior to the expiration date* of the previous PA request. Each provider is solely responsible for the timely submission of PA request renewals. Renewal requests will not be backdated for continuation of ongoing services.

Member Eligibility Changes

Topic #443

Loss of Enrollment During Treatment

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

In most cases, if a member loses enrollment midway through treatment, or at any time between the grant and enddates, Wisconsin Medicaid will *not* reimburse services (including prior authorized services) provided during an enrollment lapse. Providers should not assume Wisconsin Medicaid covers completion of services after the member's enrollment has been terminated.

To avoid potential reimbursement problems when a member loses enrollment during treatment, providers should follow these procedures:

- Ask to see the member's ForwardHealth identification card to verify the member's enrollment or consult Wisconsin's EVS (Enrollment Verification System) before the services are provided at each visit.
- When the PA (prior authorization) request is approved, verify that the member is still enrolled and eligible to receive the service before providing it. An approved PA request does not guarantee payment and is subject to the enrollment of the member.

Members are financially responsible for any services received after their enrollment has ended. If the member wishes to continue treatment, it is a decision between the provider and the member whether the service should be given and how payment will be made for the service.

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

Topic #444

Retroactive Disenrollment from State-Contracted MCOs

Occasionally, a service requiring fee-for-service PA (prior authorization) is performed during a member's enrollment period in a state-contracted MCO (managed care organization). After the service is provided, and it is determined that the member should be retroactively disenrolled from the MCO, the member's enrollment is changed to fee-for-service for the DOS (date of service). The member is continuously eligible for BadgerCare Plus or Wisconsin Medicaid but has moved from MCO enrollment to fee-for-service status.

In this situation, the state-contracted MCO would deny the claim because the member was not enrolled on the DOS. Fee-for-service would also deny the claim because PA was not obtained.

Providers may take the following steps to obtain reimbursement in this situation:

- For a service requiring PA for fee-for-service members, the provider is required to submit a retroactive PA request. For a PA request submitted on paper, indicate "RETROACTIVE FEE-FOR-SERVICE" along with a written description of the service requested/provided under "Description of Service." Also indicate the actual date(s) the service(s) was provided. For a PA request submitted via the ForwardHealth Portal, indicate "RETROACTIVE FEE-FOR-SERVICE" along with a

description of the service requested/provided under the "Service Code Description" field or include additional supporting documentation. Also indicate the actual date(s) the service(s) was provided.

- If the PA request is approved, the provider is required to follow fee-for-service policies and procedures for claims submission.
- If the PA request is denied, Wisconsin Medicaid will not reimburse the provider for the services. A PA request would be denied for reasons such as lack of medical necessity. A PA request would not be denied due to the retroactive fee-for-service status of the member.

Topic #445

Retroactive Enrollment

If a service(s) that requires PA (prior authorization) was performed during a member's [retroactive enrollment](#) period, the provider is required to submit a PA request and receive approval from ForwardHealth *before* submitting a claim. For a PA request submitted on paper, indicate the words "RETROACTIVE ENROLLMENT" at the top of the PA request along with a written description explaining that the service was provided at a time when the member was retroactively enrolled under "Description of Service." Also include the actual date(s) the service(s) was provided. For a PA request submitted via the ForwardHealth Portal, indicate the words "RETROACTIVE ENROLLMENT" along with a description explaining that the service was provided at a time when the member was retroactively eligible under the "Service Code Description" field or include additional supporting documentation. Also include the actual date(s) the service(s) was provided.

If the member was retroactively enrolled, and the PA request is approved, the service(s) may be reimbursable, and the earliest effective date of the PA request will be the date the member receives retroactive enrollment. If the PA request is denied, the provider will not be reimbursed for the service(s). Members have the right to appeal the decision to deny a PA request.

If a member requests a service that requires PA before his or her retroactive enrollment is determined, the provider should explain to the member that he or she may be liable for the full cost of the service if retroactive enrollment is not granted and the PA request is not approved. This should be documented in the member's record.

Prior Authorization Guidelines

Topic #12177

Bariatric Surgery

All covered bariatric surgery procedures (CPT (Current Procedural Terminology) procedure codes 43644, 43645, 43770-43775, 43843, 43846-43848) require PA (prior authorization). A bariatric procedure that does not meet the PA approval criteria is considered a noncovered service.

Prior Authorization Approval Criteria

The approval criteria for PA requests for covered bariatric surgery procedures include all of the following:

- The member has a BMI (body mass index) greater than 35 with at least one documented high-risk, life limiting comorbid medical conditions capable of producing a significant decrease in health status that are demonstrated to be unresponsive to appropriate treatment. There is evidence that significant weight loss can substantially improve the following comorbid conditions:
 - Sleep apnea.
 - Poorly controlled Diabetes Mellitus while compliant with appropriate medication regimen.
 - Poorly controlled hypertension while compliant with appropriate medication regimen.
 - Obesity related cardiomyopathy.
- The member has been evaluated for adequacy of prior efforts to lose weight. If there have been no or inadequate prior dietary efforts, the member must undergo 6 months of a medically supervised weight reduction program. This is separate from and not satisfied by the dietician counseling required as part of the evaluation for bariatric surgery.
- The member has been free of illicit drug use and alcohol abuse or dependence for the 6 months prior to surgery.
- The member has been obese for at least 5 years.
- The member has had a medical evaluation from the member's primary care physician, assessing preoperative condition and surgical risk and finding the member to be an appropriate candidate.
- The member has received a preoperative evaluation by an experienced and knowledgeable multidisciplinary bariatric treatment team composed of health care providers with medical, nutritional, and psychological experience. This evaluation must include, at a minimum:
 - A complete history and physical examination, specifically evaluating for obesity-related comorbidities that would require preoperative management.
 - Evaluation for any correctable endocrinopathy that might contribute to obesity.
 - Psychological or psychiatric evaluation to determine appropriateness for surgery, including an evaluation of the stability of the member in terms of tolerating the operative procedure and postoperative sequelae, as well as the likelihood of the member participating in an ongoing weight management program following surgery.
 - For members receiving active treatment for a psychiatric disorder, an evaluation by his or her treatment provider prior to bariatric surgery. The treatment provider must clear the member for bariatric surgery.
 - At least three consecutive months of participation in a weight management program prior to the date of surgery, including dietary counseling, behavioral modification, and supervised exercise, in order to improve surgical outcomes, reduce the potential for surgical complications, and establish the candidate's ability to comply with post-operative medical care and dietary restrictions. A physician's summary letter is not sufficient documentation.
 - Agreement by the member to attend a medically supervised post-operative weight management program for a minimum of six months post surgery for the purpose of ongoing dietary, physical activity, behavioral/psychological, and medical education and monitoring.
- The member is 18 years of age or older and has completed growth.
- The member has not had bariatric surgery before or there is clear evidence of compliance with dietary modification and

supervised exercise, including appropriate lifestyle changes, for at least two years.

- The bariatric center where the surgery will be performed has been approved by ASBS (Centers for Medicare and Medicaid Services/American Society for Bariatric Surgery) guidelines as a Center of Excellence and meet one of the following requirements:
 - The center has been certified by the American College of Surgeons as a Level 1 Bariatric Surgery Center.
 - The facility has been certified by the ASBS as a Bariatric Surgery Center of Excellence.

A current list of approved facilities is [available](#).

How to Submit Prior Authorization Requests

Providers may submit PA requests via the ForwardHealth Portal. Providers can upload electronically completed PA attachments and additional, required documentation.

Providers may also submit paper PA request for bariatric surgery. Paper PA requests must include the following:

- A completed [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#).
- A completed [PA/PA \(Prior Authorization/Physician Attachment, F-11016 \(07/12\)\)](#).
- Clinical documentation supporting the criteria.

Providers may submit paper PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

Length of Authorization

The length of authorization for an approved PA request for bariatric surgery is 6 months.

Services That Are Not Covered

The following procedures are considered investigational, inadequately studied, or unsafe and therefore are not covered:

- Vertical banded gastroplasty.
- Gastric balloon.
- Loop gastric bypass.
- Open adjusted gastric banding.

Topic #573

Cochlear Implant Surgeries

The rendering surgeon is required to obtain PA (prior authorization) for cochlear implant surgeries. ForwardHealth will deny claims for services relating to the surgery unless there is an approved PA request on file from the rendering surgeon for the surgery.

The surgeon may receive separate reimbursement for the device if the surgery is performed in an outpatient hospital or ASC (ambulatory surgery center) *and* the surgeon is Medicaid-enrolled as a DME (durable medical equipment) provider.

Prior Authorization Approval Criteria and Documentation Requirements for Cochlear Implant Surgery for Children

The PA approval criteria and documentation requirements for cochlear implant surgery for children ages 18 and under are as follows:

- Implants for children younger than 12 months may be approved if the Federal Drug Administration has approved use of the device in the age cohort.
- Documentation for children under 24 months of age must include the following:
 - Profound bilateral sensorineural hearing loss (with thresholds 90 dB HL (decibels hearing level) or poorer for 1000 Hz (hertz) in the better ear).
 - Lack of progress in the development of auditory skills in conjunction with appropriate binaural amplification and participation in intensive auditory rehabilitation over a three- to six-month period. (Limited benefit from amplification may be defined by test scores of less than 40 percent correct in the best aided listening condition on recorded open-set sentence tests.)
- Documentation for children 24 months of age and older must include the following:
 - Severe to profound bilateral sensorineural hearing loss (with average thresholds [500 Hz to 2000 Hz] 70 dB HL or poorer in the better ear).
 - Lack of progress in the development of auditory skills in conjunction with appropriate binaural amplification and participation in intensive auditory rehabilitation over a three- to six-month period. (Limited benefit from amplification is defined and may be quantified as an aided score of 30 percent or less on the MLNT (Multisyllabic Lexical Neighborhood Test) for children 25 months to 5 years of age, and an aided score of 30 percent or less on the LNT (Lexical Neighborhood Test) for children 5 years of age or older.)
- The child is cognitively and psychologically suitable for the implant.
- The hearing loss is not due to problems with the auditory nerve or central auditory nervous system.
- There are no medical contraindications to surgery for the implant, as determined by the CI (cochlear implant) team.
- There is radiographic evidence (CT (computed tomography) and/or MRI (magnetic resonance imaging)) of cochlear development.
- The child's state of health permits the surgical procedure, as determined by a physician.
- The ear (right or left) to be implanted must be specified.
- The family has been properly informed about all aspects of the cochlear implant, including evaluation and surgical and rehabilitation procedures.
- Documentation of family/placement stability and support.
- Local school or rehabilitation facilities are able and willing to provide a concentrated oral and/or aural rehabilitation program recommended by the CI team.

Prior Authorization Approval Criteria and Documentation Requirements for Cochlear Implant Surgery for Adults

The PA approval criteria and documentation requirements for cochlear implant surgery for adults ages 19 and older are as follows:

- The member has a moderate to profound sensorineural hearing loss (50 dB or poorer averaged over 500 Hz to 2000 Hz in the better ear).
- The member demonstrates limited benefit from amplification as defined by test scores of less than 40 percent correct in the best aided listening condition on recorded open-set sentence tests.
- The member is psychologically suitable and motivated for the procedure as determined by the CI team.
- There is radiographic evidence (CT/MRI) showing the lack of cochlear ossification, as well as the suitability for placing the electrode array in the cochlea and the receiver-stimulator in the mastoid bone.
- There are no medical contraindications for the implant, as determined by the CI team.
- The member's state of health permits the surgical procedure, as determined by a physician.

- The ear (right or left) to be implanted must be specified.

Topic #15557

Dorsal Column or Spinal Stimulator Surgeries

PA (prior authorization) is required for both a dorsal column (spinal cord) stimulator trial period and dorsal column implantation surgery. A separate PA is required for each.

All of the following criteria must be met for PA requests to be approved for temporarily implanted dorsal column stimulator electrodes for trial purposes:

- The member suffers from chronic, intractable pain.
- Other treatment modalities (pharmacological, surgical, physical, or psychological therapies) have been given an adequate trial and did not prove satisfactory or were judged to be unsuitable or contraindicated for the member. The implantation of the dorsal column stimulator is a treatment of last resort.
- The member must undergo careful screening, evaluation, and diagnosis by a multidisciplinary team prior to implantation. This screening must include:
 - Psychological and physical evaluation.
 - Psychological and physical evaluation must confirm that the pain is not believed to be of psychological origin.
 - Documented evidence of pathology of the chronic pain (i.e., an objective basis).

Except in unusual situations, the diagnosis should be either failed back surgery syndrome or complex regional pain syndrome.

- There is documentation that the pain interferes with a member's daily living activities.

For dorsal column stimulator surgery PA approval, the following criteria must be met:

- The member must complete a trial period of at least three days per the guidelines listed above for the temporarily implanted dorsal column stimulator electrodes for trial purposes.
- The member must demonstrate at least a 50 percent reduction of pain with a temporarily implanted electrode.
- The results of the trial period must be documented in the PA attachments.

Topic #12377

Gynecomastia Surgery

All [gynecomastia](#) procedures require PA (prior authorization). A gynecomastia procedure that does not meet the PA approval criteria is considered noncovered. Any charges related to the noncovered gynecomastia procedure will not be reimbursed.

Prior Authorization Policy

PA requests for gynecomastia surgery may be approved under [DHS 107.06\(2\)\(c\)](#), Wis. Admin. Code, which states PA is required for "surgical or medical procedures of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed to significantly interfere with a recipient's personal or social adjustment or employability, an example of which is cosmetic surgery."

Note: Surgical removal of excess male breast tissue is rarely indicated and is usually for cosmetic reasons as there is no functional impairment associated with this disorder.

Prior Authorization Approval Criteria

Prior authorization requests for gynecomastia surgery must meet one of the following criteria:

- Klinefelter's syndrome is diagnosed.
- Post pubertal-onset gynecomastia has persisted for one year with all of the following criteria:
 - Glandular breast tissue confirming true gynecomastia is documented on physical exam and/or mammography.
 - Gynecomastia is classified as a Grade II, III, or IV per the American Society of Plastic Surgeons classification.*
 - The condition is associated with persistent breast pain, despite the use of analgesics.
 - The use of potential gynecomastia-inducing drugs and substances has been identified and discontinued for at least one year when medically appropriate.
 - The gynecomastia persists despite correction of any underlying causes.
 - Hormonal causes including hyperthyroidism, estrogen excess, prolactinomas and hypogonadism have been excluded by appropriate laboratory testing (TSH, estradiol, prolactin, testosterone, and/or luteinizing hormone).

* American Society of Plastic Surgeons scale adapted from the McKinney and Simon, Hoffman and Khan scales:

- Grade II: Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest.
- Grade III: Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest with skin redundancy present.
- Grade IV: Marked breast enlargement with skin redundancy and feminization of the breast.

Topic #4518

Implant and Non-implant Bone-Anchored Hearing Aids

ForwardHealth has developed PA (prior authorization) approval criteria for unilateral bone-anchored hearing aid implant surgeries, bilateral bone-anchored hearing aid implant surgeries, bone-anchored hearing aid implant surgeries for profound unilateral sensorineural hearing loss with normal hearing in the opposite ear, and for bone-anchored hearing aids that do not require surgery.

When submitting a PA request for bone-anchored hearing aid implant surgery, the rendering surgeon is required to submit the following:

- [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#).
- [PA/PA \(Prior Authorization/Physician Attachment, F-11016 \(07/12\)\)](#).
- [PA/HIAS2 \(Prior Authorization Request for Hearing Instrument and Audiological Services 2, F-11021 \(07/12\)\)](#).

Approval Criteria for Unilateral Bone-Anchored Hearing Aid Implant Surgeries

The following criteria must be met for PA requests to be approved for unilateral bone-anchored hearing aid implant surgeries:

- The member is 5 years of age or older at the time of surgery.
- The member has sufficient bone volume and bone quality to support successful fixture placement as determined by the surgeon AND the surgeon determines that the implant can safely be done in a one-step procedure.
- The member has a conductive and/or mixed hearing loss (unilateral or bilateral) with pure-tone average bone-conduction thresholds (measured at 0.5, 1, 2, and 3 kHz) less than or equal to 65 dB HL. The threshold range is intended to accommodate different degrees of hearing loss and corresponding output power of the bone-anchored hearing aid unit.
- The member demonstrates an air-bone gap of at least 30 dB in the proposed implant ear.
- The member demonstrates a word recognition score greater than 60% via conventional air-conduction speech audiometry.

using single-syllable words.

- The member has one or more of the following conditions:
 - Severe chronic external otitis or otitis media.
 - Chronic draining ear through a tympanic membrane perforation.
 - Malformation of the external auditory canal or middle ear.
 - Stenosis of the external auditory canal.
 - Ossicular discontinuity or erosion that cannot be repaired.
 - Chronic dermatologic conditions such as psoriasis of the ear canal.
 - Tumors of the external canal and/or tympanic cavity.
 - Other conditions in which an air-conduction hearing aid is contraindicated for the ear to be implanted, or where the condition prevents restoration of hearing using a conventional air-conduction hearing aid.

Approval Criteria for Bilateral Bone-Anchored Hearing Aid Implant Surgeries

The following criteria must be met for PA requests to be approved for bilateral bone-anchored hearing aid implant surgeries:

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

Approval Criteria for Bone-Anchored Hearing Aid Implant Surgeries for Profound Unilateral Sensorineural Hearing Loss with Normal Hearing in the Opposite Ear

Profound unilateral sensorineural hearing loss with normal hearing in the opposite ear is sometimes referred to as unilateral sensorineural deafness or single-sided deafness (SSD).

The following criteria must be met for PA requests to be approved for bone-anchored hearing aid implant surgeries for profound unilateral sensorineural hearing loss:

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

Approval Criteria for Bone-Anchored Hearing Devices That Do Not Require Surgery

Bone-anchored hearing aids that use a processor and headband (rather than a surgically implanted device) require PA. When submitting a PA request for bone-anchored hearing devices that use a processor and headband, providers are required to submit the [PA/HIAS1 \(Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 \(05/13\)\)](#) and PA/HIAS2.

Approval for a bone-anchored hearing device that uses a processor and headband requires that the provider adhere to all PA

criteria for a unilateral bone-anchored hearing device with the exception of the surgically related criteria. The ear receiving the bone-conduction device must be specified.

Topic #12417

Pectus Excavatum/Carinatum Surgery

All [pectus excavatum/carinatum](#) procedures require PA (prior authorization). A pectus excavatum/carinatum procedure that does not meet the PA approval criteria is considered a noncovered service. Any charges related to the noncovered pectus excavatum/carinatum procedure will not be reimbursed.

Prior Authorization Policy

Congenital chest wall deformities may result in functional limitations such as activity intolerance related to cardiac or respiratory impairment. Patients often report symptoms that include mild to moderate exercise limitation, respiratory infections, and asthmatic conditions. In many cases, the deformity does not lead to functional impairment, and treatment is considered to be solely cosmetic in nature. Pectus carinatum has not been found to cause functional impairment, and surgical repair is considered to be cosmetic.

PA requests for pectus excavatum/carinatum surgery may be approved under [DHS 107.06\(2\)\(c\)](#), Wis. Admin. Code, which states PA is required for "surgical or medical procedures of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed to significantly interfere with a recipient's personal or social adjustment or employability, an example of which is cosmetic surgery."

Prior Authorization Approval Criteria for Pectus Excavatum

Any one of the following criteria must be met for PA requests for repair of severe pectus excavatum when the pectus index (i.e., Haller index^{*}) is greater than 3.25:

- Pulmonary function studies demonstrate at least moderately severe restrictive airway disease.
- Echocardiograph demonstrates finding consistent with external compression.
- Abnormal cardiovascular or ventilator limitation is evident during cardiopulmonary exercise testing.
- Documentation of progression of the deformity with associated physical symptoms other than isolated concerns of body image.

^{*} The degree of deformity can be determined by dividing the inner width of the chest at the widest point by the distance between the posterior surface of the sternum and the anterior surface of the spine. CT scans are better able to define the ratio of AP (anterior-posterior) borders to transverse diameters, also referred to as the pectus index or Haller index. Diameters are taken at the deepest level of the sternal depression. CT scan ratios that reveal transverse to AP diameter of greater than 3.25 are considered significant for pectus excavatum. A normal chest has an index of 2.5.

Topic #13797

Restorative Plastic Surgery and Procedures

PA (Prior authorization) requests for [restorative plastic surgery and procedures](#) must meet one of the following criteria:

- Documentation that supports medical necessity for the procedure included in the PA request (e.g., signs and symptoms such as pain, repeated trauma to lesion, recurrent infection).
- A psychiatric evaluation documenting procedure necessity based on significant impairment of social or personal adjustment.
- Documentation of significant impact on employability, as long as there was no other factor that could not be resolved, which

would prevent the member from being employed. Documented attempts at employment or other clear supporting evidence should be included with the PA request.

When requesting PA, a photograph of the involved area is desirable but not mandatory.

Topic #13757

Vagus Nerve Stimulator Implant Surgeries

The following criteria must be met for PA (prior authorization) requests to be approved for [VNS \(vagus nerve stimulator\) implant surgery](#):

- The member has either medically intractable partial-onset seizures for which resective or disconnection epilepsy surgery is either not an option (for personal or medical reasons) or has failed; or the member has medically intractable primary generalized, symptomatic generalized, or mixed epilepsy.
- Multiple trials of antiepileptic medications with documented compliance have either failed or have produced unacceptable side effects.
- The medical record contains documentation that the member's seizures significantly interfere with daily functioning and quality of life, and there is reason to believe that quality of life will be improved as a result of VNS.
- The member does not have other, independent diagnoses that could explain why their seizures are failing to respond to medical treatment.

Topic #12697

Wearable Cardioverter Defibrillator

Rental of a WCD (wearable cardioverter defibrillator) is a covered service with PA (prior authorization), subject to certain [billing requirements](#). The WCD is indicated for adult members at high risk for sudden cardiac death and is used on an outpatient basis. This equipment is intended for short term use under medical supervision. The WCD is designed to perform the same functions as an automatic ICD (implantable cardioverter defibrillator), but is worn outside the body and, therefore, is noninvasive.

PA requests for a WCD must document that the member meets one of the following:

- A documented episode of ventricular fibrillation or a sustained, lasting 30 seconds or longer, ventricular tachyarrhythmia. The dysrhythmia may be either spontaneous or induced during an electrophysiologic study, but may not be due to a transient or reversible cause and not occur during the first 48 hours of an acute myocardial infarction (ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) codes 427.1 [paroxysmal ventricular tachycardia] 427.42 [ventricular flutter], or 427.5 [cardiac arrest]).
- Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmia such as a long QT syndrome (ICD-9-CM code 426.82 [long QT syndrome]) or hypertrophic cardiomyopathy (ICD-9-CM code 425.1 [hypertrophic obstructive cardiomyopathy]).
- Either documented prior myocardial infarction or dilated cardiomyopathy and a measured left ventricular ejection fraction less than or equal to 35 percent.

In addition, the PA must document one of the medical contraindications to ICD implantation as follows:

- A previously implanted defibrillator that now requires removal for reasons such as mechanical complication due to automatic implantable cardiac defibrillator (ICD-9-CM code 996.04) or infection and inflammatory reaction due to cardiac device, implant, and graft (ICD-9-CM code 996.61).
- Is waiting for a heart transplant.
- Is at high risk of an arrhythmia and is expected to improve with therapy for an underlying metabolic or other medical

condition within a short time frame.

- Is waiting for ICD implantation while undergoing treatment for a systemic infection.

Denial Criteria

PA requests for a WCD will be denied if any of the following are true:

- The member is 18 years of age or younger.
- The member has a vision, hearing or developmental problem that may interfere with the perception of alarms or messages from the WCD.
- The member is taking medications that would interfere with responding to alarms or messages from the WCD.
- The member is either pregnant or breast feeding or of childbearing age and is not attempting to prevent pregnancy.
- The member will be exposed to high levels of electromagnetic interference that may prevent the WCD from operating.
- The member is unable or unwilling to wear the device continuously, except when bathing.

Submitting a Prior Authorization Request

The DME (durable medical equipment) provider must submit all of the following as part of a PA request for a WCD, regardless of the submission method:

- A completed [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#).
- A completed [PA/DMEA \(Prior Authorization/Durable Medical Equipment Attachment, F-11030 \(07/12\)\)](#). The DME provider is responsible for obtaining the required clinical information from the member's cardiologist to complete the PA/DMEA.
- Documentation supporting the PA approval criteria.

Note: The cardiologist must be an American Board of Cardiology-certified cardiologist.

Review Process

Topic #450

Clerical Review

The first step of the PA (prior authorization) request review process is the clerical review. The provider, member, diagnosis, and treatment information indicated on the [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#), [PA/HIAS1 \(Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 \(05/13\)\)](#), and [PA/DRF \(Prior Authorization/Dental Request Form, F-11035 \(07/12\)\)](#) forms is reviewed during the clerical review of the PA request review process. The following are examples of information verified during the clerical review:

- Billing and/or rendering provider number is correct and corresponds with the provider's name.
- Provider's name is spelled correctly.
- Provider is Medicaid-enrolled.
- Procedure codes with appropriate modifiers, if required, are covered services.
- Member's name is spelled correctly.
- Member's identification number is correct and corresponds with the member's name.
- Member enrollment is verified.
- All required elements are complete.
- Forms, attachments, and additional supporting clinical documentation are signed and dated.
- A current physician's prescription for the service is attached, if required.

Clerical errors and omissions are responsible for the majority of PA requests that are returned to providers for correction or additional information. Since having to return a PA request for corrections or additional information can delay approval and delivery of services to a member, providers should ensure that all clerical information is correctly and completely entered on the PA/RF, PA/DRF, or PA/HIAS1.

If clerical errors are identified, the PA request is returned to the provider for corrections before undergoing a clinical review. One way to reduce the number of clerical errors is to complete and submit PA/RFs through Web PA.

Topic #451

Clinical Review

Upon verifying the completeness and accuracy of clerical items, the PA (prior authorization) request is reviewed to evaluate whether or not each service being requested meets Wisconsin Medicaid's definition of "medically necessary" as well as other criteria.

The PA attachment allows a provider to document the clinical information used to determine whether the standards of medical necessity are met for the requested service. Wisconsin Medicaid considers certain factors when determining whether to approve or deny a PA request pursuant to [DHS 107.02\(3\)\(e\)](#), Wis. Admin. Code.

It is crucial that a provider include adequate information on the PA attachment so that the ForwardHealth consultant performing the clinical review can determine that the service(s) being requested meets all the elements of Wisconsin Medicaid's definition of "medically necessary", including elements that are not strictly medical in nature. Documentation must provide the justification for the service requested specific to the member's current condition and needs. Pursuant to [DHS 101.03\(96m\)](#), Wis. Admin. Code, "medically necessary" is a service under ch. DHS 107 that meets certain criteria.

Determination of Medical Necessity

The definition of "medically necessary" is a legal definition identifying the standards that must be met for approval of the service. The definition imposes parameters and restrictions that are both medical and nonmedical.

The determination of medical necessity is based on the documentation submitted by the provider. For this reason, it is essential that documentation is submitted completely and accurately and that it provides the justification for the service requested, specific to the member's current condition and needs. To be approved, a PA request must meet all of the standards of medical necessity including those that are not strictly medical in nature.

To determine if a requested service is medically necessary, ForwardHealth consultants obtain direction and/or guidance from multiple resources including:

- Federal and state statutes.
- Wisconsin Administrative Code.
- PA guidelines set forth by the DHS (Department of Health Services).
- Standards of practice.
- Professional knowledge.
- Scientific literature.

Services Requiring Prior Authorization

Topic #1004

An Overview

Physician services that require PA (prior authorization) are subject to change and are periodically updated by Wisconsin Medicaid. General services requiring PA include the following:

- All covered physician services if provided out-of-state under nonemergency circumstances by a provider who does not have border-status enrollment with Wisconsin Medicaid.
- Surgical or other medical procedures of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed to significantly interfere with a member's personal or social adjustment or employability.

Contact a Medicaid-enrolled pharmacist or [Provider Services](#) for information regarding possible PA or diagnosis restrictions for a particular drug.

Audiological Testing for Hearing Instruments

A [PA/POR \(Prior Authorization/Physician Otological Report, F-11019 \(07/12\)\)](#) is required for audiological testing for specifications of a hearing instrument. A photocopy of the approved hearing instrument PA request form is sent to the member who presents it to the Medicaid-enrolled audiologist or hearing instrument specialist of his or her choice.

Bariatric Surgery

[Bariatric surgery](#) for treatment of morbid obesity is allowed only in limited circumstances.

Cochlear Implants and Bone-Anchored Hearing Devices

Approval criteria for cochlear implant surgery is included in the [Cochlear and Bone-Anchored Implant Surgeries](#).

Dorsal Column or Spinal Stimulator Surgeries

Approval criteria for [dorsal column or spinal stimulator surgeries](#) are available.

Gynecomastia Surgery

Approval criteria for [gynecomastia surgery](#) are available.

Infertility and Impotence Services

Treatment of infertility and impotence are noncovered services under Wisconsin Medicaid. Drugs whose primary use is treatment of infertility or impotence may be approved through PA only when used for treatment of conditions other than infertility or impotence.

Pectus Excavatum/Carinatum Surgery

Approval criteria for [pectus excavatum surgery](#) are available.

Plagiocephaly — Occipital Plagiocephaly Cranial Banding (Cranial Remodeling Orthosis [Helmet])

PA requests for infant head molding bands (procedure code S1040) to correct skull deformities in infants require photographic and medical record documentation. The orthosis is only allowed for infants under 18 months of age at the time of initiation of service.

Penile Prosthesis

Insertion or replacement of semirigid penile prosthesis (procedure codes 54400, 54416, and 54417) may be approved through PA only when the prosthesis is employed for purposes other than treatment of impotence (e.g., to support a penile catheter). Replacement of an inflatable penile prosthesis is not a covered service.

Transplant Services

The hospital, rather than the physician, is responsible for obtaining PA for [transplant services that require PA](#). Physicians should make sure all necessary approvals have been obtained by the hospital before proceeding with a transplant operation. Wisconsin Medicaid does not require PA for collection of the donor organ.

Restorative Plastic Surgery and Procedures

Approval criteria for [restorative plastic surgery and procedures](#) are available.

Vaginal Construction

Vaginal construction (procedure codes 57291 and 57292) may be approved through PA only when performed on a female (e.g., correction of a congenital defect). It will not be approved as part of a transsexual surgery.

Vagus Nerve Stimulator Implant Surgeries

Approval criteria for [vagus nerve stimulator implant surgeries](#) are available.

Weight Management Services

All medical services (beyond five E&M (evaluation and management) office visits per calendar year) aimed specifically at weight management and procedures to reverse such services require PA.

Topic #541

Codes

Physician-related procedure codes requiring PA (prior authorization) can be found in the [interactive maximum allowable fee schedule](#).

Topic #14417

Prior Authorization Requests and Amendments for Lumizyme and Myozyme

PA (prior authorization) is required for Lumizyme and Myozyme. Prescribers, *not* pharmacy providers, are required to submit PA requests for Lumizyme and Myozyme.

Lumizyme and Myozyme are covered for BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, and Medicaid members.

Lumizyme and Myozyme are not covered for BadgerCare Plus Basic Plan or SeniorCare members.

For members enrolled in BadgerCare Plus HMOs, Medicaid SSI (Supplemental Security Income) HMOs, and most special managed care programs, claims for Lumizyme and Myozyme should be submitted to BadgerCare Plus and Medicaid on a fee-for-service basis.

Lumizyme is only available to be dispensed under a manufacturer's restricted distribution program. Providers are required to comply with the manufacturer's guidelines. For more information regarding these guidelines, providers should contact the manufacturer.

Clinical Criteria for Lumizyme

Initial Prior Authorization Approval Criteria for Lumizyme

The clinical criteria for approval of an initial PA request for Lumizyme are *all* of the following:

- The member has a diagnosis of late-onset (non-infantile) Pompe disease.
- The member's diagnosis of late-onset Pompe disease is based on *both* of the following:
 - GAA (Acid alpha-glucosidase) enzyme assay that shows reduced enzyme activity at less than 40 percent of the lab-specific normal mean value.
 - Confirmation by a second GAA enzyme activity assay in a separate sample (from purified lymphocytes, fibroblast, or muscle) or by GAA gene sequencing.
- The member is 8 years of age or older.
- The member has an FVC (forced vital capacity) 30 to 79 percent of predicted value while in the sitting position.
- The member has a postural drop in FVC (in liters) of 10 percent or more from upright to supine position.
- The member has the ability to walk 40 meters on a six-minute walk test (assistive devices permitted).
- The member has muscle weakness in the lower extremities.

Documentation that the member meets these criteria (including supporting medical records) should be submitted with the initial PA request.

Subsequent Prior Authorization Approval Criteria for Lumizyme

The clinical criteria for approval of a subsequent PA request for Lumizyme are *both* of the following:

- The member is ambulatory (assistive devices permitted).
- The member is not ventilator dependent.

Note: The prescriber should indicate the member's ambulation and ventilator status on the PA request.

Clinical Criteria for Myozyme

Initial Prior Authorization Approval Criteria for Myozyme

The clinical criteria for approval of an initial PA request for Myozyme are *all* of the following:

- The member has a diagnosis of infantile-onset Pompe disease.
- The diagnosis of infantile-onset Pompe disease is based on *both* of the following:
 - GAA enzyme assay from dried blood spot or mixed leukocytes.
 - Confirmation by at least one secondary test to support the diagnosis (e.g., GAA enzyme assay in culture of skin fibroblasts or muscle biopsy, DNA (deoxyribonucleic acid) mutational analysis, or lymphocyte vacuolation on blood films).

Documentation that the member meets these criteria (including supporting medical records) should be submitted with the initial PA request.

Subsequent Prior Authorization Approval Criterion for Myozyme

The clinical criterion for approval of a subsequent PA request for Myozyme is that the member is not ventilator dependent.

Note: The prescriber should indicate the member's ventilator status on the PA request.

Submitting Prior Authorization Requests

PA for Lumizyme and Myozyme must be requested by prescribers or their designees, not pharmacy providers. If a PA request is submitted by a pharmacy provider, it will be returned.

The following forms must be submitted with a PA request for Lumizyme or Myozyme:

- A completed [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#). (For special instructions on completing the PA/RF for Lumizyme or Myozyme, refer to "Completing the Prior Authorization Request Form" below. The full [PA/RF completion instructions for prescribers](#) are also available.
- A completed [PA/JCA \(Prior Authorization/"J" Code Attachment, F-11034 \(07/12\)\)](#). (For special instructions on completing the PA/JCA for Lumizyme or Myozyme, refer to "Completing the Prior Authorization/ "J" Code Attachment" below. The full [PA/JCA completion instructions \(Prior Authorization/"J" Code Attachment, F-11034A \(07/12\)\)](#) are also available.)

PA requests may be submitted through the following:

- [ForwardHealth Portal](#).
- [Fax](#).
- [Mail](#).

Prior Authorization Requests Submitted by Fax or Mail

Prescribers may submit paper PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste. 88
313 Blettner Blvd.
Madison WI 53784

If a prescriber or his or her designee chooses to submit a paper PA request for Lumizyme or Myozyme by fax or mail, the following must be completed and submitted to ForwardHealth:

- PA/RF for prescribers for drugs.
- PA/JCA.
- Supporting documentation, as appropriate.

The [Prior Authorization Fax Cover Sheet \(F-01176 \(12/11\)\)](#) is available for providers submitting the forms and documentation by fax.

Approved Prior Authorization Requests

Prior Authorization requests for Lumizyme and Myozyme will be approved for up to 365 days.

Special Instructions for Completion of Forms

Completing the Prior Authorization Request Form

When completing the PA/RF for Lumizyme or Myozyme, prescribers are required to enter the total quantity requested in units (where one unit equals 10 milligrams) in Element 22 of the form. (Full [PA/RF completion instructions for prescribers](#) are available.)

Completing the Prior Authorization/"J" Code Attachment

When completing the PA/JCA for Lumizyme or Myozyme, prescribers are required to enter the following information for the elements indicated (all elements on the form must be completed unless otherwise specified):

Element 4 — Drug Name

Enter Lumizyme or Myozyme.

Element 5 — Strength

Enter 50 mg vial.

Element 6 — National Drug Code

Enter the NDC (National Drug Code) from the package.

Element 7 — HCPCS "J" Code

Enter HCPCS (Healthcare Common Procedure Coding System) procedure code J0221 (Injection, alglucosidase alfa, [lumizyme], 10 mg) for Lumizyme; enter J0220 (Injection, alglucosidase alfa, not otherwise specified, 10 mg) for Myozyme.

Element 8 — Quantity Ordered

Enter the dose per administration in units, where one unit equals 10 milligrams.

Element 9 — Date Ordered Issued

Enter the date the order for the product was issued.

Element 10 — Daily Dose

Enter the dose per administration in milligrams. Enter the frequency of administration.

Element 13 — "Brand Medically Necessary"

Leave blank.

Element 14 — Diagnosis

Enter the appropriate ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis code.

Element 15 — Changes to Previous Clinical Condition

Enter a statement indicating that the member meets the ForwardHealth PA clinical criteria for Lumizyme or Myozyme, and include the member's ambulation and ventilator status to date (as appropriate for the service requested). For initial PA requests, reference attached documentation (attached documentation should be appropriate for the service requested).

Element 18 — Signature — Prescriber

The prescriber is required to sign the PA/JCA. (By signing the form, the prescriber is attesting that all information is true, to the best of his or her knowledge.)

Full [PA/JCA completion instructions \(Prior Authorization/"J" Code Attachment, F-11034A \(07/12\)\)](#) are available.

Prior Authorization Amendments

If a member's weight changes, resulting in a change in dose for Lumizyme or Myozyme, the prescriber is required to amend an approved PA request for the appropriate dose. PA requests may be amended by submitting a PA/RF to ForwardHealth on the Portal, or on paper by fax or mail.

Prescribers are required to indicate the following on PA amendment requests for Lumizyme or Myozyme:

- The member's most recent weight.
- The date the member's weight was measured.
- The new Lumizyme or Myozyme dose calculation.

Note: Prescribers have 30 days from the date of administering a dose change to amend an approved PA request for Lumizyme or Myozyme.

Topic #7877

Prior Authorization Requests and Amendments for Synagis

Synagis[®] requires PA (prior authorization). Prescribers, *not* pharmacy providers, are required to submit PA requests for Synagis[®]. Members who have previously been administered Synagis[®] will not be grandfathered and are required to have a valid PA on file for Synagis[®] for each treatment season. If the first dose of Synagis[®] is administered in a hospital, the dose does not require PA.

PA requests for Synagis[®] may be submitted beginning September 15 of each year.

When requesting PA for Synagis[®], the prescribing provider must identify the name and NPI (National Provider Identifier) of the provider who intends to submit a claim for reimbursement for Synagis[®] (i.e., the billing provider).

If the prescribing provider intends to submit the claim, the prescribing provider must list his or her name and NPI on the PA request as the billing provider.

If the prescribing provider's clinic or group intends to submit the claim, the prescribing provider must list the clinic or group's name and NPI on the PA request as the billing provider.

If, instead, a pharmacy provider intends to submit the claim, the prescribing provider must list the pharmacy provider's name and NPI on the PA request as the billing provider. In this case, it is the prescribing provider's responsibility to acquire the pharmacy provider's name and NPI.

Prescribers or their designees must request PA for Synagis[®] using only one of the following options:

- [DAPO \(Drug Authorization and Policy Override\) Center](#).
- [ForwardHealth Portal](#).
- [Fax](#).
- [Mail](#).

If prescribers call the DAPO Center to obtain PA, they may complete, sign, and date the PA request form and keep it in a member's medical records.

PA requests for Synagis[®] submitted through the Portal or by mail or fax will not be processed as 24-hour drug PA requests because providers may call the DAPO Center to obtain an immediate decision about a PA request.

Prior Authorization Requests Submitted by Fax or Mail

If a prescriber or his or her designee chooses to submit a paper PA request for Synagis[®] by fax or mail, the following must be completed and submitted to ForwardHealth:

- [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#) for physician services.
- [Prior Authorization Drug Attachment for Synagis \(F-00142 \(10/09\)\)](#).
- Supporting documentation, as appropriate.

The [Prior Authorization Fax Cover Sheet \(F-01176 \(12/11\)\)](#) is available for providers submitting the forms and documentation by fax.

Prior Authorization Amendments

Prescribing providers and billing providers may amend approved PAs for Synagis[®] if a member's weight changes, resulting in an increase in Synagis[®] units during a treatment season. Providers have 30 days from the date of administering each dose change to amend an approved PA for Synagis[®].

If the prescribing provider is not also the billing provider, the prescribing provider may only amend the PA by contacting the DAPO Center.

Billing providers may amend PA requests through the following:

- By calling the DAPO Center.
- On the Portal.
- By submitting a PA/RF by mail or fax.

To amend a PA request for Synagis[®], providers are required to provide the following information:

- The member's most recent weight and the date it was measured.
- The member's weight at the time the dose change occurred and the date it was measured.
- The requested start date for the dose change.
- The new Synagis[®] dose calculation.

Change in Billing Provider

If during the course of Synagis[®] treatment the billing provider changes, the prescribing provider (i.e., the provider who submitted the original PA request) is responsible for amending the PA. To amend the billing provider information, the prescribing provider must call the DAPO Center. The prescribing provider will be required to give the new billing provider's name and NPI.

Clinical Criteria

To be approved, PA requests must document that the member meets the following clinical criteria:

- For chronic lung disease, the member is a child younger than 24 months of age at the start of the RSV (respiratory syncytial virus) season with chronic lung disease who requires medical therapy (i.e., supplemental oxygen, bronchodilators, diuretics, or corticosteroid therapy) within six months of the start of the RSV season. In this case, a maximum of five doses of Synagis[®] will be approved.
- For congenital heart disease, the member is a child younger than 24 months of age at the start of the RSV season with hemodynamically significant cyanotic or acyanotic congenital heart disease and is receiving medication to control congestive heart failure, has moderate to severe pulmonary hypertension, or has cyanotic heart disease. In this case, a maximum of five doses of Synagis[®] will be approved.
- For immunocompromised children, the member is a child younger than 24 months of age at the start of the RSV season with a severe immunodeficiency (i.e., SCID (severe combined immunodeficiency) or advanced AIDS (Acquired Immunodeficiency Syndrome)). In this case, a maximum of five doses of Synagis[®] will be approved.

To be approved, PA requests for pre-term infants must document that the member meets the following clinical criteria:

- The member is an infant born before 29 weeks gestation (i.e., zero days through 28 weeks, six days) who is less than 12 months of age at the start of the RSV season. In this case, a maximum of five doses of Synagis[®] will be approved.
- The member is an infant born at or greater than 29 weeks gestation but less than 32 weeks gestation (i.e., 29 weeks, zero days through 31 weeks, six days) who is less than six months of age at the start of the RSV season. In this case, a maximum of five doses of Synagis[®] will be approved.
- The member is an infant born at or greater than 32 weeks gestation but less than 35 weeks gestation (i.e., 32 weeks, zero days through 34 weeks, six days) who is less than three months of age at the start of the RSV season or is born during the RSV season and has at least one of the following risk factors:
 - Infant attends child care.
 - Infant has siblings younger than five years of age.

The member should receive prophylaxis only until he or she reaches 3 months of age. The member should only receive a maximum of three monthly doses; many members will receive only one or two doses until they reach 3 months of age.

- The member is an infant born before 35 weeks gestation (i.e., 34 weeks, six days) who is less than 12 months of age at the start of the RSV season with either congenital abnormalities of the airway or a neuromuscular condition that compromises handling of respiratory secretions. In this case, a maximum of five doses of Synagis[®] will be approved.

PA requests will be approved only for the Synagis[®] treatment season of November through March. ForwardHealth will not approve more than five doses of Synagis[®] per season.

Topic #7837

Prior Authorization for Anti-Obesity Drugs

PA (Prior authorization) requests for the following anti-obesity drugs may be submitted on the [Prior Authorization Drug](#)

Attachment for Anti-Obesity Drugs (F-00163 (10/13)):

- Benzphetamine.
- Diethylpropion.
- Phentermine.
- Phendimetrazine.
- Belviq.
- Qysmia.
- Xenical[®].

Note: Anti-obesity drugs are not covered by the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, or the BadgerCare Plus Basic Plan.

Anti-obesity drugs are covered for dual eligibles enrolled in a Medicare Part D PDP (Prescription Drug Plan).

A 34-day supply is the maximum amount of any anti-obesity drug that may be dispensed each month.

Clinical Criteria for Anti-obesity Drugs

Clinical criteria for approval of a PA request for anti-obesity drugs require **one** of the following:

- The member has a BMI (body mass index) greater than or equal to 30.
- The member has a BMI greater than or equal to 27 but less than 30 *and* two or more of the following risk factors:
 - Coronary heart disease.
 - Dyslipidemia.
 - Hypertension.
 - Sleep apnea.
 - Type II diabetes mellitus.

In addition, **all** of the following must be true:

- The member is 16 years of age or older. (*Note:* Members need only to be 12 years of age or older to take Xenical[®].)
- The member is not pregnant or nursing.
- The member does not have a history of an eating disorder (e.g., anorexia, bulimia).
- The prescriber has evaluated and determined that the member does not have any medical or medication contraindications to treatment with the anti-obesity drug being requested.
- For controlled substance anti-obesity drugs, the member does not have a medical history of substance abuse or misuse.
- The member has participated in a weight loss treatment plan (e.g., nutritional counseling, an exercise regimen, a calorie-restricted diet) in the past six months and will continue to follow the treatment plan while taking an anti-obesity drug.

PA requests for anti-obesity drugs will not be renewed if a member's BMI is below 24.

Note: ForwardHealth does not cover the brand name (i.e., innovator) anti-obesity drugs if an FDA (Food and Drug Administration)-approved generic equivalent is available. ForwardHealth does not cover any brand name innovator phentermine products. In addition, ForwardHealth does not cover OTC (over-the-counter) anti-obesity drugs.

ForwardHealth will return PA requests for OTC and brand name anti-obesity drugs with generic equivalents and brand name phentermine products as noncovered services.

Clinical Criteria for Benzphetamine, Diethylpropion, Phendimetrazine, and Phentermine

If clinical criteria for anti-obesity drugs are met, initial PA requests for benzphetamine, diethylpropion, phendimetrazine, and

phentermine will be approved for up to a maximum of three months. If the member meets a weight loss goal of at least 10 pounds of his or her weight from baseline during the initial three-month approval, PA may be requested for an additional three months of treatment. The maximum length of continuous drug therapy for benzphetamine, diethylpropion, phendimetrazine, and phentermine is six months.

If the member does not meet a weight loss goal of at least 10 pounds of his or her weight from baseline during the initial three-month approval, or if the member has completed six months of continuous benzphetamine, diethylpropion, phendimetrazine, or phentermine treatment, the member must wait six months before PA can be requested for any controlled substance anti-obesity drug.

ForwardHealth allows only two weight loss attempts with this group of drugs (benzphetamine, diethylpropion, phendimetrazine, and phentermine) during a member's lifetime. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services. Members do not have appeal rights for noncovered services.

Clinical Criteria for Belviq

If clinical criteria for anti-obesity drugs are met, initial PA requests for Belviq will be approved for up to a maximum of three months. If the member meets a weight loss goal of at least five percent of his or her weight from baseline during the first three months of treatment, PA may be requested for an additional six months of treatment. If the member's weight remains below baseline, subsequent PA renewal periods for Belviq are a maximum of six months. PA requests for Belviq may be approved for a maximum treatment period of 24 continuous months of drug therapy.

If the member does not meet a weight loss goal of at least five percent of his or her weight from baseline during the initial three-month approval, or if the member's weight does not remain below baseline, or if the member has completed 24 months of continuous Belviq treatment, the member must wait six months before PA can be requested for any controlled substance anti-obesity drug.

ForwardHealth allows only two weight loss attempts with Belviq during a member's lifetime. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services. Members do not have appeal rights for noncovered services.

Clinical Criteria for Qysmia

If clinical criteria for anti-obesity drugs are met, initial PA requests for Qysmia will be approved for up to a maximum of six months. If the member meets a weight loss goal of at least five percent of his or her weight from baseline, PA may be requested for an additional six months of treatment. PA requests for Qysmia may be approved for a maximum treatment period of 12 continuous months of drug therapy.

If the member does not meet a weight loss goal of at least five percent of his or her weight from baseline during the initial six-month approval, or if the member has completed 12 months of continuous Qysmia treatment, the member must wait six months before PA can be requested for any controlled substance anti-obesity drug.

ForwardHealth allows only two weight loss attempts with Qysmia during a member's lifetime. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services. Members do not have appeal rights for noncovered services.

Clinical Criteria for Xenical®

If clinical criteria for anti-obesity drugs are met, initial PA requests for Xenical® will be approved for up to a maximum of six months. If the member meets a weight loss goal of at least 10 pounds of his or her weight from baseline during the first six months of treatment, PA may be requested for an additional six months of treatment. If the member's weight remains below baseline, subsequent PA renewal periods for Xenical® are a maximum of six months. PA requests for Xenical® may be approved for a

maximum treatment period of 24 continuous months of drug therapy.

If the member does not meet a weight loss goal of at least 10 pounds during the initial six-month approval, or if the member's weight does not remain below baseline, or if the member has completed 24 months of continuous Xenical® treatment, the member must wait six months before PA can be requested for Xenical®.

ForwardHealth allows only two weight loss attempts with Xenical® during a member's lifetime. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services. Members do not have appeal rights for noncovered services.

Submitting Prior Authorization Requests for Anti-obesity Drugs

PA requests for anti-obesity drugs must be submitted using the Prior Authorization Drug Attachment for Anti-Obesity Drugs form and must be submitted by prescribers or their designees, *not* pharmacy providers.

Prior Authorization requests for anti-obesity drugs may be submitted through the following:

- [DAPO \(Drug Authorization and Policy Override\) Center](#)
- [Portal](#)
- [Fax](#)
- [Mail](#)

Note: PA requests for anti-obesity drugs submitted by mail or fax will not be processed as 24-hour drug PA requests. If an immediate decision is needed for a PA request, providers should call the DAPO Center during the noted business hours. If prescribers choose not to use the DAPO Center, the prescriber is required to submit a [PA/RP \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#) along with the applicable PA drug attachment form with the additional medical documentation.

Prior authorization request submission procedures apply to members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare.

Topic #13157

Prior Authorization for Antipsychotic Drugs for Children 6 Years of Age and Younger

All antipsychotic drugs prescribed for oral use for all children 6 years of age and younger require PA (prior authorization).

PA requests must meet the criteria for children 6 years of age and younger to maintain coverage of an antipsychotic drug.

PA requests for antipsychotic drugs for children 6 years of age and younger must be submitted on the [Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger \(F-00556 \(01/12\)\)](#).

Claims submitted for an antipsychotic drug for children 6 years of age and younger without an approved Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger on file will be denied.

Providers should refer to the [Preferred Drug List Quick Reference](#) for a list of covered antipsychotic drugs for members enrolled in the BadgerCare Plus Standard Plan or Medicaid. Prescribers are encouraged to write prescriptions for preferred antipsychotic drugs.

Providers should refer to the [BadgerCare Plus Benchmark Plan Product List](#) for a list of covered antipsychotic drugs for

BadgerCare Plus Benchmark Plan members. Antipsychotic drugs that are not on the BadgerCare Plus Benchmark Plan Product List are noncovered. If a noncovered antipsychotic drug is necessary for a Benchmark Plan member, the prescriber should inform the member the drug is not covered and instruct the member to work with his or her pharmacy provider to determine whether or not the drug is covered by [BadgerRx Gold](#).

Prescriber Responsibilities for Antipsychotic Drugs for Children 6 Years of Age and Younger

Prescribers should determine the ForwardHealth benefit plan in which a member is enrolled before writing a prescription for an antipsychotic drug.

If the child is 6 years of age or younger and requires an antipsychotic drug, the prescriber is required to complete the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger. PA requests and prescriptions must be faxed, mailed, or sent with the member to the pharmacy provider.

The pharmacy provider will use the completed form to submit a PA request to ForwardHealth. Prescribers should not submit the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger form directly to ForwardHealth.

PA requests for covered antipsychotic drugs for children 6 years of age and younger are approved at the active ingredient level. Therefore, an approved PA request allows any covered NDC (National Drug Code) drug with the same active ingredient of the prior authorized drug to be covered with the same PA. For example, if a member has an approved PA request for risperidone 1 mg tablet and the prescriber orders a new prescription for risperidone 2 mg tablet, an amended PA request or new PA request is not required.

Pharmacy Responsibilities for Antipsychotic Drugs for Children 6 Years of Age and Younger

Pharmacy providers should ensure that they have received the completed Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger from the prescriber. Pharmacy providers should determine the ForwardHealth benefit plan in which the member is enrolled. After the benefit plan is confirmed, pharmacy providers should review the program-specific covered drug or product list. For Standard Plan and Medicaid members, pharmacy providers should review the Preferred Drug List Quick Reference for the most current list of preferred and non-preferred drugs. For Benchmark Plan members, pharmacy providers should review the BadgerCare Plus Benchmark Plan Product List.

If a Standard Plan or Medicaid member presents a prescription for a non-preferred antipsychotic drug, the pharmacy provider is encouraged to contact the prescriber to discuss preferred drug options. The prescriber may choose to change the prescription to a preferred antipsychotic drug, if medically appropriate for the member.

For Benchmark Plan members, if an antipsychotic drug is a noncovered drug, claims for the drug may be submitted to BadgerRx Gold.

It is important that pharmacy providers work with prescribers to ensure that members are given appropriate assistance regarding coverage information and the PA request submission process for antipsychotic drugs. Pharmacy providers are responsible for the submission of the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger to ForwardHealth. Pharmacy providers are required to retain a completed and signed copy of the PA form.

Required Documentation

The following factors will be considered for the approval of a PA request for antipsychotics for children 6 years of age and younger and should be documented on the PA request:

- Diagnoses — There are appropriate indications for the use of antipsychotic medications in young children with certain diagnoses including autism spectrum disorders, psychotic disorders, tic disorders, and severe agitation or aggression that may accompany severe mood and developmental disorders.
- Prescriber's credentials — When ForwardHealth reviews a particular PA request, the prescriber's credentials are considered as one's area of expertise that may or may not include familiarity with the antipsychotic class of medications.
- Target symptoms — To appropriately prescribe and track the use of antipsychotic medications, the prescriber needs to carefully identify the primary target symptom so that the family, mental health clinicians, teachers, and all involved adults can help clarify and determine the efficacy of the medication.
- Polypharmacy — There are many concerns regarding the use of multiple psychoactive medications in children. The Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger requires the notation of any psychoactive medications, concurrent medications, and previous medication trials in the preceding 12 months.
- Mental health resources — The available resources for evaluating and treating a child and family are critical for understanding the clinical approach and role of medication in a child's treatment plan. Noting the involvement of resources (such as Birth to 3, in-home therapy, family therapy, child psychiatry consultation, outpatient contacts, hospitalization, acute/chronic medical needs) will help the PA consultants understand the clinical resources available to a particular child and family.
- BMI (Body Mass Index) — Antipsychotic medications can have profoundly adverse effects on weight, glucose, and lipids. Because of these well-documented side effects, the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger requires the submission of a BMI measurement with each PA request. A BMI calculator is available and may be found on the Centers for Disease Control and Prevention Web site at <http://apps.nccd.cdc.gov/dnpabmi/>.
- Foster placement — Several studies have shown that children in foster care have a relatively high incidence of receiving antipsychotic medications. Indicate whether or not the child is currently placed in foster care.
- PDL (Preferred Drug List) — If the prescriber is requesting a non-preferred antipsychotic medication, clinical justification must be provided (e.g., failed trials of preferred medications including doses, length of treatment, clinical response, side effects, target symptoms). PA requests for brand medically necessary drugs must be submitted separately with clinical justification that the brand name drug is medically necessary.

Psychiatrists board-certified in child psychiatry developed the PA criteria and they are consulting with ForwardHealth to review the PA requests. A PA request may be returned for additional information prior to adjudication, so it is important that contact information for the prescriber or the prescriber's office be accurate to facilitate the adjudication process. The child psychiatrist consultants will be available to review specific questions about a particular PA request after the PA request is received by ForwardHealth.

Prior Authorization Request Submission Methods

Pharmacy providers are encouraged to submit all PA requests for antipsychotic drugs for Standard Plan and Medicaid members 6 years of age and younger using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system. The STAT-PA submission allows ForwardHealth to capture and use information to monitor prescribing of antipsychotic drugs for children under the DUR (Drug Utilization Review) program.

If the PA request is not approved through the STAT-PA system or if the PA request is for a [brand medically necessary](#) antipsychotic drug, pharmacy providers are required to submit the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger form via one of the following:

- The ForwardHealth Portal.
- Fax.
- Mail.

For Benchmark Plan members, all Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger forms must be submitted on either the Portal or by fax or mail.

PA requests for all antipsychotic drugs submitted via the Portal or by fax or mail to ForwardHealth must include the following:

- A [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#).
- The Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger.
- Any additional supporting documentation from the prescriber.

Approved Prior Authorization Requests for Antipsychotic Drugs for Children 6 Years of Age and Younger

PA requests for all antipsychotic drugs for children 6 years of age and younger will be approved at the ingredient level.

Neither a new PA request nor a PA amendment is needed if the antipsychotic drug the child is taking has changed and the new drug contains the same active ingredient as the original drug approved or if the child is taking multiple strengths of the same drug.

PA decision letters for antipsychotic drugs for children 6 years of age and younger will include a message stating: "The prior authorization for this drug has been approved at the active ingredient level instead of the drug strength and dosage form level. Additional PAs are not needed for a different strength of this same drug."

Topic #15777

Prior Authorization for Botulinum Toxins to Treat Other Diagnoses

The following must be submitted to request PA (prior authorization) for a botulinum toxin for a diagnosis not on the [Diagnosis Code-Restricted Physician-Administered Drugs data table](#) (with the exception of [chronic migraines](#)):

- A completed [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#)
- A completed [PA/JCA \(Prior Authorization/"J" Code Attachment, F-11034 \(07/12\)\)](#).

In addition to the PA request forms, providers are required to submit peer-reviewed medical literature to support the proven efficacy of the botulinum toxin for the specific condition that is to be treated.

Providers may submit PA requests and necessary documentation on the [ForwardHealth Portal](#), by [fax](#), or by [mail](#).

Topic #7817

Prior Authorization for Lipotropics, Omega-3 Acids

Note: For the most current list of preferred and non-preferred drugs in this drug class, refer to the [Preferred Drug List Quick Reference](#).

Clinical PA (prior authorization) is required for all omega-3 acids, including preferred omega-3 acids. PA requests for omega-3 acids must be submitted by prescribers or their designees, *not* pharmacy providers.

PA requests for Lovaza[®] and Vascepa[®] for BadgerCare Plus Standard Plan, Medicaid, and SeniorCare members should be submitted using the [Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids \(F-00162 \(07/13\)\)](#).

PA requests for omega-3 acids may be submitted through the following:

- [DAPO \(Drug Authorization and Policy Override\) Center](#).
- [ForwardHealth Portal](#).
- [Fax](#).
- [Mail](#).

Note: PA requests for omega-3 acids submitted by fax or mail will not be processed as 24-hour drug PA requests because providers may call the DAPO Center to obtain an immediate decision about a PA request.

Prior Authorization Requests Submitted by Fax or Mail

If a prescriber or his or her designee chooses to submit a PA request for an omega-3 acid by fax or mail, the following must be completed and submitted to ForwardHealth:

- A [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#) (which should be completed using the instructions for prescribers for drugs).
- The Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids form.
- Supporting documentation, as appropriate.

The [Prior Authorization Fax Cover Sheet \(F-01176 \(12/11\)\)](#) is available for providers submitting the forms and documentation by fax.

Clinical Criteria for Lovaza®

Clinical criteria for approval of a PA request for Lovaza® for members who are *not* currently taking Lovaza® are **all** of the following:

- The member is 18 years of age or older.
- The member does not have an allergy or sensitivity to fish.
- **One** of following is true:
 - The member currently has a triglyceride level of 500 mg/dL or greater.
 - The member currently has a triglyceride level **below** 500 mg/dL and **both** of the following are true:
 - The member has had a triglyceride level of 500 mg/dL or greater in the past.
 - The member has a current triglyceride level between 200 and 499 mg/dL while taking a fibrate or niacin. (If a member's triglyceride level is below 200mg/dL, the PA request will be denied.)

Clinical criteria for approval of a PA request for Lovaza® for members who are currently taking Lovaza® are **all** of the following:

- The member is 18 years of age or older.
- The member does not have an allergy or sensitivity to fish.
- The member's current triglyceride level has decreased by at least 20 percent from the baseline level.
- The member has had a triglyceride level of 500 mg/dL or greater in the past.

Clinical Criteria for Non-Preferred Omega-3 Acids

Clinical criteria for approval of a PA request for a non-preferred omega-3 acid for members *not* currently taking a non-preferred omega-3 acid are **all** of the following:

- The member is 18 years of age or older.
- The member does not have an allergy or sensitivity to fish.
- In the past year, the member has taken the maximum dose of Lovaza® for at least four consecutive months and **one** of the following is true:

- The member failed to achieve at least a 30 percent decrease in triglyceride level from baseline.
- The member's triglyceride level remained at 500 mg/dL or greater.
- **One** of following is true:
 - The member currently has a triglyceride level of 500 mg/dL or greater.
 - The member currently has a triglyceride level **below** 500 mg/dL and **both** of the following are true:
 - The member has had a triglyceride level of 500 mg/dL or greater in the past.
 - The member has a current triglyceride level between 200 and 499 mg/dL while taking a fibrate, niacin, or Lovaza®. (If a member's triglyceride level is below 200mg/dL, the PA request will be denied.)

Clinical criteria for approval of a PA request for a non-preferred omega-3 acid for members currently taking a non-preferred omega-3 acid are **all** of the following:

- The member is 18 years of age or older.
- The member does not have an allergy or sensitivity to fish.
- The member's current triglyceride level has decreased by at least 20 percent from the baseline level.
- The member has had a triglyceride level of 500 mg/dL or greater in the past.

Approved Prior Authorization Requests for Omega-3 Acids

PA requests for omega-3 acids may be initially approved for four months. Renewal PA requests may be approved for up to a maximum of one year. For an **initial renewal** PA request to be approved, the member's triglyceride levels must decrease by at least 20 percent from the baseline triglyceride level. For **subsequent renewal** PA requests to be approved, the member must continue to maintain the improved triglyceride level.

Lipid panels, including triglyceride levels, within the previous three months are required for each yearly PA renewal request thereafter.

Topic #15097

Prior Authorization for OnabotulinumtoxinA (Botox®)

Botox® is a neurotoxin used to treat a number of diagnoses including (but not limited to) cervical dystonia, limb spasticity, strabismus, chronic migraines, and urinary incontinence.

Botox® is covered for members enrolled in the BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, and Medicaid. It is not covered for BadgerCare Plus Basic Plan or SeniorCare members.

For members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, claims for Botox® should be submitted to BadgerCare Plus and Medicaid fee-for-service for reimbursement.

Botox® for Use to Treat Chronic Migraines

A dosing range of 155-195 units is considered acceptable for the use of Botox® to treat chronic migraines.

Providers Who May Administer Botox® To Treat Chronic Migraines

The following licensed and Medicaid-enrolled providers familiar with and experienced in the use of Botox® may administer this agent to treat chronic migraines:

- Nurse practitioners.

- Physician assistants.
- Physicians.

Botox[®] for Use to Treat Chronic Migraines Requires Prior Authorization

When using Botox[®] to treat *chronic* migraines, the rendering provider is required to request PA (prior authorization) on the [Prior Authorization Drug Attachment for OnabotulinumtoxinA \(Botox[®]\) to Treat Chronic Migraines \(F-00701 \(08/13\)\)](#). This form must be used to request PA for Botox[®] to treat chronic migraines and must be filled out completely. Unless requested by ForwardHealth, providers are not required to submit additional clinical documentation with the PA request form. Unusual situations may be summarized using the space in Element 25 of the PA request form. Incomplete PA requests will be returned or denied.

Claims for Botox[®] to treat chronic migraines will be denied if an approved PA request is not on file for the member.

Submitting Prior Authorization Requests for Botox[®] to Treat Chronic Migraines

To request PA for Botox[®] to treat chronic migraines, the rendering provider is required to submit the following:

- A completed [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#).
- A completed Prior Authorization Drug Attachment for Onabotulinumtoxin A (Botox[®]) to Treat Chronic Migraines.

PA requests for Botox[®] to treat chronic migraines may be submitted on the [ForwardHealth Portal](#), by [fax](#), or by [mail](#).

Initial Prior Authorization Approval Criteria for Botox[®] to Treat Chronic Migraines

Following are clinical criteria for approval of an initial PA request for Botox[®] to treat chronic migraines:

- The member is 18 years of age or older.
- The service is ordered by the provider who has evaluated the member and diagnosed the member as experiencing chronic migraines using the [revised International Headache Society criteria for chronic migraines](#).

Note: The requesting provider is required to be the rendering provider of the Botox[®] treatment to the member.

- The member has experienced headaches (tension-type and/or migraine) for **three or more** months that have lasted **four or more** hours per day on **15 or more** days per month, with **eight or more** headache days per month being migraines/probable migraines (and that are not due to medication overuse or attributed to another causative disorder).
- The member scored a grade indicating moderate to severe disability on the [MIDAS \(Migraine Disability Assessment\)](#) test, or on a similar validated tool. The MIDAS test was developed by the American Headache Society for Headache Education.
- The rendering provider has discussed alternative non-pharmacological treatment options with the member, such as behavioral therapies, physical therapies, and lifestyle modifications.
- **One** of the following is true:
 - The member has tried migraine prophylaxis medications from **three or more** of the drug categories listed below and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
 - Antidepressants.
 - Anticonvulsants.
 - Beta blockers.
 - Calcium channel blockers.
 - Other drugs.
 - The member has a medical condition that prevents him or her from trying migraine prophylaxis medications from

three or more of the drug categories listed above, or there is a clinically significant drug interaction with a medication the member is currently taking that prevents him or her from trying migraine prophylaxis medications from **three or more** of the drug categories listed above.

If an initial PA request for Botox[®] to treat chronic migraines is approved, it will be approved for no more than two treatments in six months.

First Renewal Prior Authorization Approval Criterion for Botox[®] to Treat Chronic Migraines

The clinical criterion for approval of a first renewal PA request for Botox[®] to treat chronic migraines is that the member has experienced clinically significant and documented improvement in the frequency or duration of chronic migraines using at least **one** of the following indicators:

- Reduction in acute services, emergency services, or need for rescue treatment for acute chronic migraines.
- At least a 40 percent reduction in the frequency, severity, or length of chronic migraines.
- Improved assessment score on the MIDAS test or on a similar validated tool.
- Reduced use of analgesics.

If a first renewal PA request for Botox[®] to treat chronic migraines is approved, it may be approved for up to two additional treatments in a six-month period.

Subsequent Renewal Prior Authorization Approval Criterion for Botox[®] to Treat Chronic Migraines

The clinical criterion for approval of a subsequent renewal PA request for Botox[®] to treat chronic migraines is that the member **continues to experience** the previously documented clinically significant improvement in the frequency or duration of chronic migraines as a result of Botox[®] treatment.

If a subsequent renewal PA request for Botox[®] to treat chronic migraines is approved, it may be approved for up to four additional treatments in a 12-month period.

Note: Members who have previously received Botox[®] treatments for chronic migraines are required to meet the above approval criteria in order for claims for the Botox[®] treatments to be reimbursed. PA requests for Botox[®] to treat chronic migraines that were approved prior to implementation of the above approval criteria will be honored until the expiration date.

Botox[®] for Use to Treat Diagnoses Other than Chronic Migraines

For uses other than the treatment of chronic migraines, Botox[®] is a diagnosis-restricted drug. Botox[®] is covered without PA for any of the diagnoses listed on the [Diagnosis Code-Restricted Physician-Administered Drugs data table](#). The table lists ForwardHealth-approved diagnoses with their corresponding ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis codes. Claims for Botox[®] not for use to treat chronic migraines are only reimbursable without PA when submitted with one of the approved ICD-9-CM diagnosis codes.

Diagnosis codes not listed on the Diagnosis Code-Restricted Physician-Administered Drugs data table require PA.

Submitting Prior Authorization Requests for Botox[®] to Treat Diagnoses Other than Chronic Migraines

When PA is required, the following forms must be submitted to request PA for Botox[®] to treat diagnoses other than chronic

migraines:

- A completed PA/RF.
- A completed [PA/JCA \(Prior Authorization/"J" Code Attachment, F-11034 \(07/12\)\)](#).

Like PA requests for Botox[®] to treat chronic migraines or urinary incontinence, PA requests for Botox[®] to treat diagnoses not listed on the Diagnosis Code-Restricted Physician-Administered Drugs data table may be submitted on the Portal, by fax, or by mail. In addition to the PA request forms, providers are required to submit peer-reviewed medical literature to support the proven efficacy of the requested use of Botox[®].

Topic #10737

Screening Computed Tomographic Colonography

All PA (prior authorization) requests for screening CT (computed tomographic) colonography will be adjudicated and processed by [MedSolutions](#), a private radiology benefits manager authorized to administer PA for [advanced imaging services](#) on behalf of ForwardHealth. Providers are required to work directly with MedSolutions to submit PA requests for screening CT colonography, unless the provider is [exempt](#) from the PA requirement for CT imaging services.

Situations Requiring New Requests

Topic #452

Change in Billing Providers

Providers are required to submit a new PA (prior authorization) request when there is a change in billing providers. A new PA request must be submitted with the new billing provider's name and billing provider number. The expiration date of the PA request will remain the same as the original PA request.

Typically, as no more than one PA request is allowed for the same member, the same service(s), and the same dates, the new billing provider is required to send the following to ForwardHealth's PA Unit:

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

Topic #5197

Changes to Member Enrollment Status

Changes to a member's enrollment status may affect PA (prior authorization) determinations. In the following cases, providers are required to obtain valid, approved PA for those services that require PA:

- A member enrolled in the BadgerCare Plus Standard Plan has a change in income level and becomes eligible for the BadgerCare Plus Benchmark Plan. The member's enrollment status changes to Benchmark Plan.
- A member enrolled in the Benchmark Plan has a change in income level or medical condition and becomes eligible for the Standard Plan or Medicaid. The member's enrollment status changes to Standard Plan or Medicaid accordingly.

Some changes in a member's enrollment status do not affect PA determinations. In the following cases, providers are not required to obtain separate PA because PA will continue to be valid:

- A member enrolled in the Standard Plan becomes eligible for Medicaid coverage. PA granted under the Standard Plan will be valid for Medicaid.
- A member switches from the Standard Plan to the Benchmark Plan and there is already a valid PA on file for the member under the Benchmark Plan.
- A member switches from the Benchmark Plan to the Standard Plan or Medicaid and there is already a valid PA on file for the member under the Standard Plan or Medicaid.

Providers are encouraged to [verify enrollment](#) before every office visit or service rendered. Verifying enrollment will help providers identify changes in member enrollment status and take appropriate actions to obtain PA for services when necessary.

The first time a member switches plans, the provider is required to submit a new PA request, including all required PA forms and attachments. If a member switches back into either of the plans and there is a valid, approved PA on file under that plan, the provider does not need to submit a new PA request.

Providers who have a provider account on the ForwardHealth Portal may use the Portal to check if a valid PA is on file for the service.

Calculating Limits for Services Requiring Prior Authorization

Any limits that pertain to services requiring PA will accumulate separately under each plan.

Topic #5417

Prior Authorization for BadgerCare Plus Plans

Providers are required to obtain PA separately for the Standard Plan, the Benchmark Plan, the BadgerCare Plus Core Plan, and the BadgerCare Plus Basic Plan for the same or similar services. If a member's enrollment status changes, PA granted under one plan will not be valid for the other plans. Providers are required to submit new PA requests in these cases to obtain a valid PA for the member. Separate PAs are required due to differences in coverage between the Standard Plan, the Benchmark Plan, the Core Plan, and the Basic Plan.

Topic #453

Examples

Examples of when a new PA (prior authorization) request must be submitted include the following:

- A provider's billing provider changes.
- A member requests a provider change that results in a change in billing providers.
- A member's enrollment status changes and there is not a valid PA on file for the member's current plan (i.e., BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, Medicaid).

If the *rendering* provider indicated on the PA request changes but the *billing* provider remains the same, the PA request remains valid and a new PA request does *not* need to be submitted.

Topic #454

Services Not Performed Before Expiration Date

Generally, a new PA (prior authorization) request with a new requested start date must be submitted to ForwardHealth if the amount or quantity of prior authorized services is not used by the expiration date of the PA request and the service is still medically necessary.

Submission Options

Topic #12597

278 Health Care Services Review — Request for Review and Response Transaction

Providers may request PA (prior authorization) electronically using the 278 (278 Health Care Services Review — Request for Review and Response) transaction, the standard electronic format for health care service PA requests.

Compliance Testing

Trading partners may conduct compliance testing for the 278 transaction.

After receiving an "accepted" 999 (999 Functional Acknowledgment) for a test 278 transaction, trading partners are required to call the [EDI \(Electronic Data Interchange\) Helpdesk](#) to request the production 278 transaction set be assigned to them.

Submitting Prior Authorization Requests

Submitting an initial PA request using the 278 transaction does not result in a real-time approval and cannot be used to request [PA for drugs](#) and [diabetic supplies](#).

After submitting a PA request via a 278 transaction, providers will receive a real-time response indicating whether the transaction is valid or invalid. If the transaction is invalid, the response will indicate the reject reason(s), and providers can correct and submit a new PA request using the 278 transaction. A real-time response indicating a valid 278 transaction will include a [PA number](#) and a pending status. The PA request will be placed in a status of "Pending - Fiscal Agent Review."

The 278 transaction does not allow providers to submit [supporting clinical information](#) as required to adjudicate the PA request.

Trading partners cannot submit the 278 transaction through PES (Provider Electronic Solutions). In order to submit the 278 transaction, trading partners will need to use their own software or contract with a software vendor.

Topic #7857

Drug Authorization and Policy Override Center

The [DAPO \(Drug Authorization and Policy Override\) Center](#) is a specialized drug helpdesk for prescribers, their designees, and pharmacy providers to submit PA (prior authorization) requests for specific drugs and diabetic supplies and to request policy overrides for specific policies over the telephone. After business hours, prescribers may leave a voicemail message for DAPO Center staff to return the next business day.

The DAPO Center is staffed by pharmacists and certified pharmacy technicians.

Prior Authorization Requests and Policy Override Decisions

Providers who call the DAPO Center to request a PA or policy override are given an immediate decision about the PA or policy

override, allowing members to receive drugs or diabetic supplies in a timely manner. The DAPO Center reviews PA requests and policy overrides for members enrolled in BadgerCare Plus, Medicaid, and SeniorCare.

Prior Authorization Requests

Prescribers or their billing providers are required to be enrolled in Wisconsin Medicaid to submit PA requests to ForwardHealth. Prescribers who are enrolled in Wisconsin Medicaid should indicate their name and NPI (National Provider Identifier) as the billing provider on PA requests. Providers who are not enrolled in Wisconsin Medicaid should indicate the name and NPI of the Wisconsin Medicaid-enrolled billing provider (e.g., clinic) with which they are affiliated on PA requests.

When calling the DAPO Center, a pharmacy technician will ask prescribers a series of questions based on a Prior Authorization Drug Attachment form. Prescribers are encouraged to have all of the information requested on the appropriate Prior Authorization Drug Attachment completed or the member's medical record available when they call the DAPO Center. DAPO Center staff will ask for the name of the caller and the caller's credentials. (i.e., Is the caller an RN (registered nurse), physician's assistant, certified medical assistant?)

Generally by the end of the call, if clinical PA criteria are met, DAPO Center staff will approve the PA request based on the information provided by the caller. If the PA request is approved, a decision notice letter will be mailed to the billing provider. After a PA has been approved, the prescriber should send the prescription to the pharmacy and the member can pick up the drug or diabetic supply. The member does not need to wait for the prescriber to receive the decision notice to pick up the drug or diabetic supply at the pharmacy.

Note: If the provider receives a decision notice letter for a drug for which he or she did not request PA, the provider should notify the DAPO Center within 14 days of receiving the letter to inactivate the PA.

If a prescriber or his or her designee calls the DAPO Center to request PA and the clinical criteria for the PA are not met, the caller will be informed that the PA request is not approved because it does not meet the clinical criteria. If the prescriber chooses to submit additional medical documentation for consideration, he or she may submit the PA request to ForwardHealth for review by a pharmacist. The prescriber is required to submit a [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#) and the applicable PA drug attachment form with the additional medical documentation. Documentation may be submitted to ForwardHealth through the Portal or by fax or mail.

Providers with questions about pharmacy policies and procedures may continue to call [Provider Services](#).

Policy Override Decisions

When calling the DAPO Center to request a policy override, the following information must be provided:

- Member information.
- Provider information.
- Prescription information.
- The reason for the override request.

Topic #455

Fax

Faxing of all PA (prior authorization) requests to ForwardHealth may eliminate one to three days of mail time. The following are recommendations to avoid delays when faxing PA requests:

- Providers should follow the PA fax procedures.
- Providers should *not* fax the same PA request more than once.

- Providers should *not* fax *and* mail the same PA request. This causes delays in processing.

PA requests containing X-rays, dental molds, or photos as documentation must be mailed; they may not be faxed.

To help safeguard the confidentiality of member health care records, providers should include a fax transmittal form containing a confidentiality statement as a cover sheet to all faxed PA requests. The [Prior Authorization Fax Cover Sheet \(F-01176 \(12/11\)\)](#) includes a confidentiality statement and may be photocopied.

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

Prior Authorization Fax Procedures

Providers may fax PA requests to ForwardHealth at (608) 221-8616. PA requests sent to any fax number other than (608) 221-8616 may result in processing delays.

When faxing PA requests to ForwardHealth, providers should follow the guidelines/procedures listed below.

Fax Transmittal Cover Sheet

The completed fax transmittal cover sheet must include the following:

- Date of the fax transmission.
- Number of pages, including the cover sheet. The ForwardHealth fax clerk will contact the provider by fax or telephone if all the pages do not transmit.
- Provider contact person and telephone number. The ForwardHealth fax clerk may contact the provider with any questions about the fax transmission.
- Provider number.
- Fax telephone number to which ForwardHealth may send its adjudication decision.
- To: "ForwardHealth Prior Authorization."
- ForwardHealth's fax number ([608] 221-8616). PA requests sent to any other fax number may result in processing delays.
- ForwardHealth's telephone numbers. For specific PA questions, providers should call [Provider Services](#). For faxing questions, providers should call (608) 224-6124.

Incomplete Fax Transmissions

If the pages listed on the initial cover sheet do not all transmit (i.e., pages stuck together, the fax machine has jammed, or some other error has stopped the fax transmission), or if the PA request is missing information, providers will receive the following by fax from the ForwardHealth fax clerk:

- A cover sheet explaining why the PA request is being returned.
- Part or all of the original incomplete fax that ForwardHealth received.

If a PA request is returned to the provider due to faxing problems, providers should do the following:

- Attach a completed cover sheet with the number of pages of the fax.
- Resend the entire original fax transmission and the additional information requested by the fax clerk to (608) 221-8616.

General Guidelines

When faxing information to ForwardHealth, providers should not reduce the size of the [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#) or the [PA/HIAS1 \(Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020](#)

[\(05/13\)](#) to fit on the bottom half of the cover page. This makes the PA request difficult to read and leaves no space for consultants to write a response if needed or to sign the request.

If a photocopy of the original PA request and attachments is faxed, the provider should make sure these copies are clear and legible. If the information is not clear, it will be returned to the provider.

If the provider does not indicate his or her fax number, ForwardHealth will mail the decision back to the provider.

ForwardHealth will attempt to fax a response to the PA request to a provider three times. If unsuccessful, the PA request will be mailed to the provider.

If providers are not sure if an entire fax was sent, they should call ForwardHealth's fax clerk at (608) 224-6124, to inquire about the status of the fax.

Prior Authorization Request Deadlines

Faxing a PA request eliminates one to three days of mail time. However, the adjudication time of the PA request has not changed. All actions regarding PA requests are made within the [predetermined time frames](#).

Faxed PA requests received after 1:00 p.m. will be considered as received the following business day. Faxed PA requests received on a Saturday, Sunday, or holiday will be processed on the next business day.

Avoid Duplicating Prior Authorization Requests

After faxing a PA request, providers should not send the original paperwork by mail. Mailing the original paperwork after faxing the PA request will create duplicate PA requests in the system and may result in a delay of several days to process the faxed PA request.

Refaxing a PA request before the previous PA request has been returned will also create duplicate PA requests and may result in delays.

Response Back from ForwardHealth

Once ForwardHealth reviews a PA request, ForwardHealth will fax one of three responses back to the provider:

- "Your approved, modified, or denied PA request(s) is attached."
- "Your PA request(s) requires additional information (see attached). Resubmit the entire PA request, including the attachments, with the requested additional information."
- "Your PA request(s) has missing pages and/or is illegible (see attached). Resubmit the entire PA request, including the attachments."

Resubmitting Prior Authorization Requests

When resubmitting a faxed PA request, providers are required to resubmit the faxed copy of the PA request, including attachments. This will allow the provider to obtain the earliest possible grant date for the PA request (apart from backdating for retroactive enrollment). If any attachments or additional information that was requested is received without the rest of the PA request, the information will be returned to the provider.

Topic #458

ForwardHealth Portal Prior Authorization

Providers can use the PA (prior authorization) features on the ForwardHealth Portal to do the following:

- Submit PA requests and amendments for all services that require PA.
- Save a partially completed PA request and return at a later time to finish completing it.
- Upload PA attachments and additional supporting clinical documentation for PA requests.
- [Receive](#) decision notice letters and returned provider review letters.
- [Correct](#) returned PA requests and PA amendment requests.
- Change the status of a PA request from "Suspended" to "Pending."
- Submit additional supporting documentation for a PA request that is in "Suspended" or "Pending" status.
- [Search and view](#) previously submitted PA requests or saved PA requests.
- Print a PA cover sheet.

Submitting Prior Authorization Requests and Amendment Requests

Providers can submit PA requests for all services that require PA to ForwardHealth via the secure Provider area of the Portal. To save time, providers can copy and paste information from plans of care and other medical documentation into the appropriate fields on the PA request. Except for those providers exempt from NPI (National Provider Identifier) requirements, NPI and related data are required on PA requests submitted via the Portal.

When completing PA attachments on the Portal, providers can take advantage of an Additional Information field at the end of the PA attachment that holds up to five pages of text that may be needed.

Providers may also submit amendment requests via the Portal for PA requests with a status of "Approved" or "Approved with Modifications."

Saving Partially Completed Prior Authorization Requests

Providers do not have to complete PA requests in one session; they can save partially completed PA requests at any point after the Member Information page has been completed by clicking on the Save and Complete Later button, which is at the bottom of each page. There is no limit to how many times PA requests can be saved.

Providers can complete partially saved PA requests at a later time by logging in to the secure Provider area of the Portal, navigating to the Prior Authorization home page, and clicking on the Complete a Saved PA Request link. This link takes the provider to a Saved PA Requests page containing all of the provider's PA requests that have been saved.

Once on the Saved PA Requests page, providers can select a specific PA request and choose to either continue completing it or delete it.

Note: The ability to save partially completed PA requests is only applicable to new PA requests. Providers cannot save partially completed PA amendments or corrections to returned PA requests or amendments.

30 Calendar Days to Submit or Re-Save Prior Authorization Requests

Providers must submit or re-save PA requests within 30 calendar days of the date the PA request was last saved. After 30 calendar days of inactivity, a PA request is automatically deleted, and the provider has to re-enter the entire PA request.

The Saved PA Requests page includes a list of deleted PA requests. This list is for information purposes only and includes saved PA requests that have been deleted due to inactivity (it does *not* include PA requests deleted by the provider). Neither providers nor ForwardHealth are able to retrieve PA requests that have been deleted.

Submitting Completed Prior Authorization Requests

ForwardHealth's initial receipt of a PA request occurs when the PA request is submitted on the Portal. Normal backdating policy applies based on the date of initial receipt, not on the last saved date. Providers receive a confirmation of receipt along with a PA number once a PA request is submitted on the Portal.

PA Attachments on the Portal

Almost all PA request attachments can be completed and submitted on the Portal. When providers are completing PA requests, the Portal presents the necessary attachments needed for that PA request. For example, if a physician is completing a PA request for physician-administered drugs, the Portal will prompt a [PA/JCA \(Prior Authorization/"J" Code Attachment, F-11034 \(07/12\)\)](#) and display the form for the provider to complete. Certain PA attachments cannot be completed online or uploaded.

Providers may also upload an electronically completed version of the paper PA attachment form. However, when submitting a PA attachment electronically, ForwardHealth recommends completing the PA attachment online as opposed to uploading an electronically completed version of the paper attachment form to reduce the chances of the PA request being returned for clerical errors.

All PA request attachment forms are available on the Portal to download and print to submit by fax or mail.

Providers may also choose to submit their PA request on the Portal and mail or fax the PA attachment(s) and/or additional supporting documentation to ForwardHealth. If the PA attachment(s) are mailed or faxed, a system-generated [Portal PA Cover Sheet \(F-11159 \(10/08\)\)](#) must be printed and sent with the attachment to ForwardHealth for processing. Providers must list the attachments on the Portal PA Cover Sheet. When ForwardHealth receives the PA attachments by mail or fax, they will be matched up with the [PA/RF \(Prior Authorization Request Form, F-11018 \(05/13\)\)](#) that was completed on the Portal.

Note: If the cover sheet could not be generated while submitting the PA request due to technical difficulties, providers can print the cover sheet from the main Portal PA page.

Before submitting any PA request documents, providers should save or print a copy for their records. Once the PA request is submitted, it cannot be retrieved for further editing.

As a reminder, ForwardHealth does not mail back any PA request documents submitted by providers.

Additional Supporting Clinical Documentation

ForwardHealth accepts additional supporting clinical documentation when the information cannot be indicated on the required PA request forms and is pertinent for processing the PA request or PA amendment request. Providers have the following options for submitting additional supporting clinical information for PA requests or PA amendment requests:

- Upload electronically.
- Mail.
- Fax.

Providers can choose to upload electronic supporting information through the Portal in the following formats:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg).
- PDF (Portable Document Format) (.pdf).
- Rich Text Format (.rtf).
- Text File (.txt).
- OrthoCAD™ (.3dm) (for dental providers).

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

with a ".3dm" extension.

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

In addition, providers can also upload additional supporting clinical documentation via the Portal when:

- Correcting a PA request or PA amendment request that is in a "Returned — Provider Review" status.
- Submitting a PA amendment request.

If submitting supporting clinical information via mail or fax, providers are prompted to print a system-generated Portal PA Cover Sheet to be sent with the information to ForwardHealth for processing. Providers must list the additional supporting information on the Portal PA Cover Sheet.

ForwardHealth will return PA requests and PA amendments requests when the additional documentation could have been indicated on the PA/RF and PA attachments or when the pertinent information is difficult to find.

"Suspended" Prior Authorization Requests

For PA requests in a "Suspended" status, the provider has the option to:

- Change a PA request status from "Suspended" to "Pending."
- Submit additional documentation for a PA request that is in "Suspended" or "Pending" status.

Changing a Prior Authorization Request from "Suspended" to "Pending"

The provider has the option of changing a PA request status from "Suspended — Provider Sending Info" to "Pending" if the provider determines that additional information will not be submitted. Changing the status from "Suspended — Provider Sending Info" to "Pending" will allow the PA request to be processed without waiting for additional information to be submitted. The provider can change the status by searching for the suspended PA request, checking the box indicating that the PA request is ready for processing without additional documentation, and clicking the Submit button to allow the PA request to be processed by ForwardHealth. There is an optional free form text box, which allows providers to explain or comment on why the PA request can be processed.

Submitting Additional Supporting Clinical Documentation for a Prior Authorization Request in "Suspended" or "Pending" Status

There is an Upload Documents for a PA link on the PA home page in the provider secured Home Page. By selecting that link, providers have the option of submitting additional supporting clinical documentation for a PA request that is in "Suspended" or "Pending" status. When submitting additional supporting clinical documentation for a PA request that is in "Suspended" status, providers can choose to have ForwardHealth begin processing the PA request or to keep the PA request suspended. Prior authorization requests in a "Pending" status are processed regardless.

Note: When the PA request is in a "Pending" status and the provider uploads additional supporting clinical documentation, there may be up to a four-hour delay before the documentation is available to ForwardHealth in the system. If the uploaded information was received after the PA request was processed and the PA request was returned for missing information, the provider may resubmit the PA request stating that the missing information was already uploaded.

Topic #456

Mail

Any type of PA (prior authorization) request may be submitted on paper. Providers may mail completed PA requests, amendments to PA requests, and requests to enddate a PA request to ForwardHealth at the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

Topic #457

STAT-PA

Providers can submit STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) requests for a limited number of services (e.g., certain drugs, selected orthopedic shoes, lead inspections for HealthCheck). The STAT-PA system is an automated system accessed by providers by touch-tone telephone that allows them to receive an immediate decision for certain PA (prior authorization) requests.

NPI (National Provider Identifier) and related data are required when using the STAT-PA system.

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

Note: A PA request cannot be submitted through STAT-PA for members enrolled in the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, or the BadgerCare Plus Basic Plan. PA requests for members enrolled in the Benchmark Plan, the Core Plan, and the Basic Plan may be submitted online via the ForwardHealth Portal or on paper.

Provider Enrollment and Ongoing Responsibilities

8

Archive Date:01/02/2014

Provider Enrollment and Ongoing Responsibilities:Documentation

Topic #6277

1099 Miscellaneous Forms

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

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

Topic #1640

Availability of Records to Authorized Personnel

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

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

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

Also, state-contracted MCOs (managed care organizations), including HMOs (health maintenance organizations) and SSI (Supplemental Security Income) HMOs, are not reimbursed for the reproduction costs covered in their contract with the DHS (Department of Health Services).

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

Topic #200

Confidentiality and Proper Disposal of Records

ForwardHealth supports member rights regarding the confidentiality of health care and other related records, including an applicant or member's billing information or medical claim records. An applicant or member has a right to have this information safeguarded, and the provider is obligated to protect that right. Use or disclosure of any information concerning an applicant or member (including an applicant or member's billing information or medical claim records) for any purpose not connected with

program administration is prohibited unless authorized by the applicant or member (program administration includes contacts with third-party payers that are necessary for pursuing third-party payment and the release of information as ordered by the court).

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

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

HIPAA Privacy and Security Regulations

Definition of Protected Health Information

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

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

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

Requirements Regarding "Unsecured" Protected Health Information

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

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

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

Actions Required for Proper Disposal of Records

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

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

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

on the [NIST \(National Institute of Standards and Technology\) Web site](#).

For more information regarding securing PHI, providers may refer to [Health Information Privacy](#) on the HHS Web site.

Wisconsin Confidentiality Laws

[Section 134.97](#), Wis. Stats., requires providers and their business partners who are not subject to HIPAA regulations to comply with Wisconsin confidentiality laws pertaining to the disposal of health care and related records containing PHI.

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

"Personally Identifiable Data" Protected

According to [s.134.97\(1\)\(e\)](#), Wis. Stats., the types of records protected are those containing "personally identifiable data."

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

Actions Required for Proper Disposal of Records

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

Businesses Affected

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

Continuing Responsibilities for All Providers After Ending Participation

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

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

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

Penalties for Violations

Any covered entity provider or provider's business associate who violates federal HIPAA regulations regarding the confidentiality

and proper disposal of health care and related records may be subject to criminal and/or civil penalties, including any or all of the following:

- Fines up to \$1.5 million per calendar year.
- Jail time.
- Federal HHS Office of Civil Rights enforcement actions.

For entities not subject to HIPAA, [s.134.97\(4\)](#), Wis. Stats., imposes penalties for violations of confidentiality laws. Any provider or provider's business partner who violates Wisconsin confidentiality laws may be subject to fines up to \$1,000 per incident or occurrence.

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

Topic #201

Financial Records

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

Topic #202

Medical Records

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

Topic #199

Member Access to Records

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

Fees for Health Care Records

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

Per [s. 146.81\(4\)](#), Wis. Stats., health care records are all records related to the health of a patient prepared by, or under the supervision of, a health care provider.

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

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

The DHS (Department of Health Services) adjusts the [amounts](#) a provider may charge for providing copies of a member's health care records yearly per [s. 146.83\(3f\)\(c\)](#), Wis. Stats.

Topic #16157

Policy Requirements for Use of Electronic Signatures on Electronic Health Records

Effective December 1, 2013, 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 [s. 137.11\(8\), Wis. Stats.](#), 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 his or her complete name).
- Number (performer may type a number unique to him or her).
- Initials (performer may type initials unique to him or her).

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 handwritten 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 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 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(b).
 - 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(b).
 - 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 Secure Hash Algorithm 1 (SHA-1) as specified by the NIST () 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 and/or security/privacy analyst.)
- Ensure the electronic health record 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 electronic health record 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 [DHS 106.02\(9\)\(a\)](#), Wis. Admin. Code. This required maintenance of records is typically required by any third-party insurance company and is not unique to ForwardHealth.

Topic #204

Record Retention

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

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

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

Maintaining Confidentiality of Records

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

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

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

Reviews and Audits

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

Topic #205

Records Requests

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

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

Request from a Member or Authorized Person

If the request for a member's billing information or medical claim records is from a member or authorized person acting on behalf

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

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

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

Request from an Attorney, Insurance Company, or Power of Attorney

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

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

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

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

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

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

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

Request for a Statement from a Dual Eligible

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

Topic #1646

Release of Billing Information to Government Agencies

Providers are permitted to release member information without informed consent when a written request is made by the DHS

(Department of Health Services) or the federal HHS (Department of Health and Human Services) to perform any function related to program administration, such as auditing, program monitoring, and evaluation.

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

Ongoing Responsibilities

Topic #220

Accommodating Members with Disabilities

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

Topic #215

Change in Ownership

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

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

The following provider types require Medicare enrollment and/or [DQA \(Division of Quality Assurance\) certification](#) for Wisconsin Medicaid enrollment change in ownerships:

- Ambulatory surgery centers.
- ESRD (end-stage renal disease) services providers.
- FQHCs (federally qualified health centers).
- Home health agencies.
- Hospice providers.
- Hospitals (inpatient and outpatient).
- Nursing homes.
- Outpatient rehabilitation facilities.
- Rehabilitation agencies.
- RHCs (rural health clinics).

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

Providers with questions about change in ownership should call [Provider Services](#).

Repayment Following Change in Ownership

Medicaid-enrolled providers who sell or otherwise transfer their business or business assets are required to repay ForwardHealth for any erroneous payments or overpayments made to them by Wisconsin Medicaid. If necessary, the provider to whom a

transfer of ownership is made will also be held liable by ForwardHealth for repayment. Therefore, prior to final transfer of ownership, the provider acquiring the business is responsible for contacting ForwardHealth to ascertain if he or she is liable under this provision.

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

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

Division of Health Care Access and Accountability
Bureau of Program Integrity
PO Box 309
Madison WI 53701-0309

ForwardHealth has the authority to enforce these provisions within four years following the transfer of a business or business assets. Refer to [s. 49.45\(21\)](#), Wis. Stats., for complete information.

Topic #219

Civil Rights Compliance (Nondiscrimination)

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

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

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

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

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

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

Providers are required to be in compliance with the previously mentioned laws as they are currently in effect or amended. Providers who employ 25 or more employees and receive \$25,000 or more annually in Medicaid reimbursement are also

required to comply with the DHS (Department of Health Services) [Affirmative Action and Civil Rights Compliance Plan](#) requirements. Providers that employ less than 25 employees and receive less than \$25,000 annually in Medicaid reimbursement are required to comply by submitting a Letter of Assurance and other appropriate forms.

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

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

For more information on the acts protecting members from discrimination, refer to the civil rights compliance information in the Enrollment and Benefits booklet. The booklet is given to new ForwardHealth members by local county or tribal agencies. Potential ForwardHealth members can request the booklet by calling [Member Services](#).

Title VI of the Civil Rights Act of 1964

This act requires that all benefits be provided on a nondiscriminatory basis and that decisions regarding the provision of services be made without regard to race, color, or national origin. Under this act, the following actions are prohibited, if made on the basis of race, color, or national origin:

- Denying services, financial aid, or other benefits that are provided as a part of a provider's program.
- Providing services in a manner different from those provided to others under the program.
- Aggregating or separately treating clients.
- Treating individuals differently in eligibility determination or application for services.
- Selecting a site that has the effect of excluding individuals.
- Denying an individual's participation as a member of a planning or advisory board.
- Any other method or criteria of administering a program that has the effect of treating or affecting individuals in a discriminatory manner.

Title VII of the Civil Rights Act of 1964

This act prohibits differential treatment, based solely on a person's race, color, sex, national origin, or religion, in the terms and conditions of employment. These conditions or terms of employment are failure or refusal to hire or discharge compensation and benefits, privileges of employment, segregation, classification, and the establishment of artificial or arbitrary barriers to employment.

Federal Rehabilitation Act of 1973, Section 504

This act prohibits discrimination in both employment and service delivery based solely on a person's disability.

This act requires the provision of reasonable accommodations where the employer or service provider cannot show that the accommodation would impose an undue hardship in the delivery of the services. A reasonable accommodation is a device or service modification that will allow the disabled person to receive a provider's benefits. An undue hardship is a burden on the program that is not equal to the benefits of allowing that handicapped person's participation.

A handicapped person means any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

In addition, Section 504 requires "program accessibility," which may mean building accessibility, outreach, or other measures that

allow for full participation of the handicapped individual. In determining program accessibility, the program or activity will be viewed in its entirety. In choosing a method of meeting accessibility requirements, the provider shall give priority to those methods that offer a person who is disabled services that are provided in the most integrated setting appropriate.

Americans with Disabilities Act of 1990

Under Title III of the ADA (Americans with Disabilities Act) of 1990, any provider that operates an existing public accommodation has four specific requirements:

1. Remove barriers to make his or her goods and services available to and usable by people with disabilities to the extent that it is readily achievable to do so (i.e., to the extent that needed changes can be accomplished without much difficulty or expense).
2. Provide auxiliary aids and services so that people with sensory or cognitive disabilities have access to effective means of communication, unless doing so would fundamentally alter the operation or result in undue burdens.
3. Modify any policies, practices, or procedures that may be discriminatory or have a discriminatory effect, unless doing so would fundamentally alter the nature of the goods, services, facilities, or accommodations.
4. Ensure that there are no unnecessary eligibility criteria that tend to screen out or segregate individuals with disabilities or limit their full and equal enjoyment of the place of public accommodation.

Age Discrimination Act of 1975

The Age Discrimination Act of 1975 prohibits discrimination on the basis of age in programs and activities receiving federal financial assistance. The Act, which applies to all ages, permits the use of certain age distinctions and factors other than age that meet the Act's requirements.

Topic #198

Contracted Staff

Under a few circumstances (e.g., personal care, case management services), providers may contract with non-Medicaid-enrolled agencies for services. Providers are legally, programmatically, and fiscally responsible for the services provided by their contractors and their contractors' services.

When contracting services, providers are required to monitor the contracted agency to ensure that the agency is meeting member needs and adhering to ForwardHealth requirements.

Providers are also responsible for informing a contracted agency of ForwardHealth requirements. Providers should refer those with whom they contract for services to ForwardHealth publications for program policies and procedures. ForwardHealth references and publications include, but are not limited to, the following:

- Wisconsin Administrative Code.
- *ForwardHealth Updates*.
- The Online Handbook.

Providers should encourage contracted agencies to visit the ForwardHealth Portal regularly for the most current information.

Topic #216

Examples of Ongoing Responsibilities

Responsibilities for which providers are held accountable are described throughout the Online Handbook. Medicaid-enrolled providers have responsibilities that include, but are not limited to, the following:

- Providing the same level and quality of care to ForwardHealth members as private-pay patients.
- Complying with all state and federal laws related to ForwardHealth.
- Obtaining PA (prior authorization) for services, when required.
- Notifying members in advance if a service is not covered by ForwardHealth and the provider intends to collect payment from the member for the service.
- Maintaining accurate medical and billing records.
- Retaining preparation, maintenance, medical, and financial records, along with other documentation, for a period of not less than five years from the date of payment, except rural health clinic providers who are required to retain records for a minimum of six years from the date of payment.
- Billing only for services that were actually provided.
- Allowing a member access to his or her records.
- Monitoring contracted staff.
- Accepting Medicaid reimbursement as payment in full for covered services.
- Keeping provider information (i.e., address, business name) current.
- Notifying ForwardHealth of changes in ownership.
- Responding to Medicaid revalidation notifications.
- Safeguarding member confidentiality.
- Verifying member enrollment.
- Keeping up-to-date with changes in program requirements as announced in ForwardHealth publications.

Topic #217

Keeping Information Current

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: Healthcare 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, which can be accessed through their secure ForwardHealth Portal account.

The demographic maintenance tool allows providers to securely, efficiently, and conveniently update their information. In most cases, once information is submitted through the demographic maintenance tool, providers' files will be immediately updated. If providers' files are immediately updated, providers will receive a confirmation message above the panel from which they submitted their information indicating that their information was *updated* successfully. In some cases, however, ForwardHealth may need to manually verify information, which may take additional processing time and will result in a Change Notification letter being sent to providers.

The [Demographic Maintenance Tool User Guide](#) provides specific information on using the demographic maintenance tool.

Manual Verification

If ForwardHealth needs to manually verify changes before providers' files can be updated, providers will receive a confirmation message upon submission indicating that their information was *uploaded* successfully. An Application Submitted panel will display recommending that providers print a copy of the changes for their records and indicate that ForwardHealth may contact them if additional information is required. Once ForwardHealth verifies the changes and updates providers' files, ForwardHealth will mail providers a Change Notification letter. 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 may correct the information using the demographic maintenance tool. Providers may contact [Provider Services](#) if they have questions regarding the letter.

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 may 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 calling (608) 266-8481. Since the DQA will inform ForwardHealth of the changes, providers do not need to also notify ForwardHealth.

Topic #577

Legal Framework

The following laws and regulations provide the legal framework for BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid:

- Federal Law and Regulation:
 - Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
 - Regulation — Title 42 CFR Parts 430-498 and Parts 1000-1008 (Public Health).
- Wisconsin Law and Regulation:
 - Law — Wisconsin Statutes: [49.43-49.499](#), [49.665](#), and [49.473](#).
 - Regulation — Wisconsin Administrative Code, Chapters [DHS 101](#), [102](#), [103](#), [104](#), [105](#), [106](#), [107](#), and [108](#).

Laws and regulations may be amended or added at any time. Program requirements may not be construed to supersede the provisions of these laws and regulations.

The information included in the ForwardHealth Portal applies to BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid. BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid are administered by the DHS (Department of Health Services). Within the DHS, the DHCAA (Division of Health Care Access and Accountability) is directly responsible for managing these programs.

Topic #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 (800) 310-0865. Refer to the [RAC Web site](#) for additional information regarding HMS RAC activities.

Topic #13277

Reporting Suspected Waste, Fraud, and Abuse

The DHS (Department of Health Services) OIG (Office of Inspector General) investigates fraud and abuses including, but not limited to, the following:

- Billing Medicaid for services or equipment that were not provided.
- Submitting false applications for a DHS-funded assistance program such as Medicaid, BadgerCare Plus, WIC (Special Supplemental Nutrition Program for Women, Infants, and Children), or FoodShare.
- Trafficking FoodShare benefits.
- Crime, misconduct, and/or mismanagement by a DHS employee, official, or contractor.

Those who suspect fraudulent activity in Medicaid programs are required to notify the OIG if they have reason to believe that a person is misusing or abusing any DHS health care program or the ForwardHealth identification card.

[Section 49.49](#), Wis. Stats., defines actions that represent member misuse or abuse of benefits and the resulting sanctions that may be imposed. Providers are under no obligation to inform the member that they are misusing or abusing their benefits. A provider may not confiscate a ForwardHealth card from a member in question.

Reporting Suspected Fraud and Abuse

Those who suspect any form of fraud, waste, or abuse of a program by providers, trading partners, billing services, agencies, or recipients of any government assistance program are required to report it. Those reporting allegations of fraud and abuse may remain anonymous. However, not providing contact information may prevent OIG from fully investigating the complaint if questions arise during the review process.

If a provider suspects that someone is committing fraudulent activities or is misusing his or her ForwardHealth card, the provider is required to notify ForwardHealth by one of the following methods:

- Going to the OIG fraud and abuse reporting [Web site](#).
- Calling the DHS fraud and abuse hotline at (877) 865-3432.

The following information is helpful when reporting fraud and abuse:

- A description of the fraud, waste, and/or abuse, including the nature, scope, and timeframe of the activity in question. The description should include sufficient detail for the complaint to be evaluated.
- The names and dates of birth (or approximate ages) of the people involved, as well as the number of occurrences and length of the suspected activity.
- The names and date(s) of other people or agencies to which the activity may have been reported.

After the allegation is received, the DHS OIG will evaluate it and take appropriate action. If the name and contact information of the person reporting the allegation was provided, the OIG may be in contact to verify details or ask for additional information.

Prescription

Topic #520

Disposable Medical Supplies and Durable Medical Equipment

All DME (durable medical equipment) and DMS (disposable medical supplies) require a physician or physician assistant prescription signed and dated by the prescriber except for the following DMS:

- Hearing instrument accessories.
- Hearing instrument batteries.
- Hearing instrument repairs.

Prescribers are reminded that they are required to determine that all DME and DMS items are medically necessary before a prescription is written. More information about coverage and limitations is available under the [DMS](#) and [DME service areas](#) of this Online Handbook.

Breast Pumps

Wisconsin Medicaid reimburses for the prescribing of breast pumps as part of an E&M (evaluation and management) office visit. Physicians are required to document clinical requirements of an individual's need for a breast pump. Wisconsin Medicaid requires the following criteria be met:

- The member recently delivered a baby and a physician has ordered or recommended mother's breast milk for the infant.
- Documentation indicates there is the potential for adequate milk production.
- Documentation indicates there is a long-term need for and planned use of the breast pump to obtain a milk supply for the infant.
- The member is capable of being trained to use the breast pump as indicated by the physician or provider.
- Current or expected physical separation of mother and infant would make breastfeeding difficult (e.g., illness, hospitalization, work), or there is difficulty with "latch on" due to physical, emotional, or developmental problems of the mother or infant.

The optional [Breast Pump Order \(F-1153 \(02/09\)\)](#) form is to be completed by the provider, given to the provider of the breast pump, and kept in the member's medical record.

Physicians or nurse practitioners may prescribe breast pumps for members that can then be obtained through a Medicaid-enrolled DME provider or pharmacy. Wisconsin Medicaid does not reimburse prescribing providers for supplying breast pumps, unless they are also Medicaid-enrolled as a DME provider or a pharmacy.

Topic #525

General Requirements

It is vital that prescribers provide adequate supporting clinical documentation for a pharmacy or other dispensing providers to fill a prescription. Except as otherwise provided in federal or state law, a prescription must be in writing or given orally and later reduced to writing by the provider filling the prescription. The prescription must include the following information:

- The name, strength, and quantity of the drug or item prescribed.
- The service required, if applicable.
- The date of issue of the prescription.
- The prescriber's name and address.
- The member's name and address.
- The prescriber's signature (if the prescriber writes the prescription) and date signed.
- The directions for use of the prescribed drug, item, or service.

Drug Enforcement Agency Number Audits

All prescriptions for controlled substances must indicate the DEA (Drug Enforcement Agency) number of the prescriber on all prescriptions. DEA numbers are not required on claims or PAs (prior authorizations).

Members in Hospitals and Nursing Homes

For hospital and nursing home members, prescriptions must be entered into the medical and nursing charts and must include the previously listed information. Prescription orders are valid for no more than one year from the date of the prescription except for controlled substances and prescriber-limited refills that are valid for shorter periods of time.

Topic #11117

Opioid Monthly Prescription Fill Limit

[Opioid drugs](#) are limited to five prescription fills per calendar month for BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, BadgerCare Plus Basic Plan, Wisconsin Medicaid, and SeniorCare members.

These limits do not affect members who are in a nursing home or hospice care.

The following drugs will be exempt from the opioid monthly prescription fill limit:

- Suboxone film and tablet.
- Buprenorphine tablet.
- Methadone solution.
- Opioid antitussive liquid.

Prescriber Responsibilities

If a member enrolled in the Standard Plan, Medicaid, and SeniorCare require more than five opioid prescription fills in a month, the prescriber may request a policy override through the [DAPO \(Drug Authorization and Policy Override\) Center](#). An override is required for each opioid fill that exceeds the five prescription fill limit per calendar month.

Members enrolled in the Benchmark Plan, the Core Plan, and the Basic Plan are not eligible to receive an opioid monthly prescription fill limit.

When calling the DAPO Center to request a policy override for opioids, the following information must be provided:

- Prescriber's name and NPI (National Provider Identifier).
- Member's name and ID.
- Pharmacy's name and telephone number where the member attempted to have the prescription filled.
- Date the prescription was attempted to be filled.

- Drug name, strength, and quantity.
- Instructions for use.

The DAPO Center will provide information to the prescriber regarding the member's recent medication history.

If the prescriber determines an override is medically necessary, the DAPO Center will record the override, and the prescriber should contact the member and the pharmacy. When contacting the member, the prescriber should use this opportunity to discuss the appropriate use of opioids.

If the prescriber decides that it is not medically necessary to override the opioid monthly prescription fill limit, the prescriber should contact the member and discuss follow-up care. If the override is not given, the prescriber should contact the pharmacy to have the prescription canceled.

Pharmacy Responsibilities

When pharmacies are contacted by a prescriber and notified that an override is available, the pharmacy should submit the claim for the opioid. Pharmacies are responsible for submitting claims for opioids within three days of the override being obtained by the prescriber. If the pharmacy provider does not submit the claim within the three day time period, the claim will be denied.

Note: If the pharmacy provider contacts the DAPO Center to obtain an override, the DAPO Center will inform the pharmacy provider that the prescriber is responsible for obtaining the override.

If a prescriber does not override the opioid monthly prescription fill limit for members enrolled in the Standard Plan, Medicaid, or SeniorCare, the service is considered noncovered.

If a pharmacy has difficulty with claim submission related to the opioid monthly prescription limit, contact the DAPO Center.

Exceptions

Opioid prescription fill limit exceptions are covered for members enrolled in the Standard Plan, Medicaid, and SeniorCare.

Members enrolled in the Benchmark Plan, the Core Plan, and the Basic Plan are not eligible to receive an opioid prescription fill limit exception.

Schedule III-V drugs

If the prescriber is unavailable, the DAPO Center will grant a 96-hour supply exception to exceed the opioid monthly prescription fill limit for a Schedule III-V drug if the following conditions are met:

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contact the prescriber (or the prescriber's agent) but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacy must document on the prescription order that the prescriber is not available.
- The pharmacist confirmed that dispensing a 96-hour supply is medically necessary.
- A 96-hour supply exception was not previously granted within the current calendar month.

If the prescriber is unavailable and the DAPO Center is closed, then pharmacy providers may dispense a 96 hour supply if the following conditions are met:

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contact the prescriber (or the prescriber's agent), but the prescriber is unavailable (e.g., clinic is closed).

- The pharmacy must document on the prescription order that the prescriber is not available.
- The pharmacist confirmed that dispensing a 96-hour supply is medically necessary.
- A 96-hour supply exception was not previously granted within the current calendar month.

Only one 96-hour supply exception for opioid drugs is allowed per calendar month. Once the DAPO Center is open, the pharmacy must call to obtain the 96-hour supply exception.

The 96-hour supply exception may be retroactive up to five days (i.e., back dated).

If a 96-hour supply exception has already been provided in the same calendar month, the prescription is a noncovered service.

Schedule II Drugs

If the prescriber is unavailable, the DAPO Center may grant an exception for a Schedule II drug if the following conditions are met:

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contact the prescriber (or the physician's agent), but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacy must document on the prescription order that the prescriber is not available.
- The pharmacist confirmed that it is medically necessary to dispense the drug.
- An exception for Schedule II drugs was not previously granted within the current calendar month.
- The pharmacist may dispense the full quantity indicated on the prescription order.

If the prescriber is unavailable and the DAPO Center is closed, the pharmacy may dispense an exception for a Schedule II drug if the following conditions are met:

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contact the prescriber (or the physician's agent), but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacy documented on the prescription order that the prescriber is not available.
- The pharmacist confirmed that it is medically necessary to dispense the drug.
- The pharmacist may dispense the full quantity indicated on the prescription order.

Pharmacy providers are required to submit a [Noncompound Drug Claim \(F-13072 \(07/12\)\)](#) form, with a [Pharmacy Special Handling Request \(F-13074 \(07/12\)\)](#) form, indicating the following:

- The drug dispensed was a Schedule II drug and the opioid monthly prescription fill limit was exceeded.
- The pharmacy attempted to contact the prescriber (or the physician's agent), but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacist is required to provide justification why it was medically necessary to dispense the Schedule II opioid before discussing with the prescriber an exception to the opioid monthly prescription fill limit.

Only one exception for Schedule II opioid is allowed per calendar month.

If a Schedule II opioid exception has already been provided in the same calendar month, the prescription is a noncovered service.

Topic #523

Prescriber Information for Drug Prescriptions

Most legend and certain OTC (over-the-counter) drugs are covered. (A legend drug is one whose outside package has the

legend or phrase "Caution, federal law prohibits dispensing without a prescription" printed on it.)

Coverage for some drugs may be restricted by one of the following policies:

- PDL (Preferred Drug List).
- PA (prior authorization).
- Brand medically necessary drugs that require PA.
- Diagnosis-restricted drugs.
- Age-restricted and gender-restricted drugs.

Prescribers are encouraged to write prescriptions for drugs that do not have restrictions; however, processes are available to obtain reimbursement for medically necessary drugs that do have restrictions.

For the most current prescription drug information, refer to the [pharmacy data tables](#). Providers may also call [Provider Services](#) for more information.

Preferred Drug List

Most preferred drugs on the [PDL](#) do *not* require PA, although these drugs may have other restrictions (e.g., age, diagnosis); non-preferred drugs *do* require PA. Prescribers are encouraged to write prescriptions for preferred drugs; however, a PA process is available for non-preferred drugs if the drugs are medically necessary. Prescribers are encouraged to try more than one preferred drug, if medically appropriate for the member, before prescribing a non-preferred drug.

Prescriber Responsibilities for Non-preferred Drugs

Prescribers should determine the ForwardHealth benefit plan in which a member is enrolled before writing a prescription. If a member is enrolled in the BadgerCare Plus Standard Plan, Medicaid, or SeniorCare, prescribers are encouraged to write prescriptions for preferred drugs. Prescribers are encouraged to prescribe more than one preferred drug before a non-preferred drug is prescribed.

If a non-preferred drug or a preferred drug that requires clinical PA is medically necessary for a member, the prescriber is required to complete a PA request for the drug. Prescribers are required to complete the appropriate [PA form](#) and submit it to the pharmacy provider where the prescription will be filled. When completing the PA form, prescribers are reminded to provide a handwritten signature and date on the form. PA request forms may be faxed or mailed to the pharmacy provider, or the member may carry the form with the prescription to the pharmacy provider. The pharmacy provider will use the completed form to submit a PA request to ForwardHealth. The prescriber is required to attest on the form that the member meets the clinical criteria for PA approval. Prescribers should not submit PA forms to ForwardHealth.

Prescribers and pharmacy providers are required to retain a completed copy of the PA form.

For BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, and BadgerCare Plus Basic Plan members, prescribers should be aware of drugs covered by the benefit plan and write prescriptions for drugs that are covered by the plan.

If a noncovered drug is medically necessary for a Benchmark Plan, Core Plan, or Basic Plan member, the prescriber should inform the member the drug is not covered by the benefit plan. The prescriber should instruct the member to work with his or her pharmacy provider to determine whether or not the drug is covered by BadgerRx Gold.

Diagnosis-Restricted Drugs

Prescribers are required to include a diagnosis description on prescriptions for those [drugs that are diagnosis-restricted](#).

Prescribing Drugs Manufactured by Companies Who Have Not Signed the

Rebate Agreement

By federal law, pharmaceutical manufacturers who participate in state Medicaid programs must sign a rebate agreement with the CMS (Centers for Medicare and Medicaid Services). BadgerCare Plus, Medicaid, and SeniorCare will cover legend and specific categories of OTC products of manufacturers who have signed a rebate agreement.

Note: SeniorCare does not cover OTC drugs, except insulin.

ForwardHealth has identified [drug manufacturers who have signed the rebate agreement](#). By signing the rebate agreement, the manufacturer agrees to pay ForwardHealth a rebate equal to a percentage of its "sales" to ForwardHealth.

Drugs of companies choosing not to sign the rebate agreement, with few exceptions, are not covered. A Medicaid-enrolled pharmacy can confirm for prescribers whether or not a particular drug manufacturer has signed the agreement.

Members Enrolled in the BadgerCare Plus Standard Plan, Medicaid, or SeniorCare (Levels 1 and 2a)

BadgerCare Plus, Medicaid, and SeniorCare levels 1 and 2a may cover certain FDA (Food and Drug Administration)-approved legend drugs through the PA process even though the drug manufacturers did not sign rebate agreements.

Prescribers are required to complete the [appropriate section\(s\) of the PA/DGA \(Prior Authorization/Drug Attachment, F-11049 \(10/13\)\)](#) as it pertains to the drug being requested.

Included with the PA, the prescriber is required to submit documentation of medical necessity and cost-effectiveness that the non-rebated drug is the only available and medically appropriate product for treating the member. The documentation must include the following:

- A copy of the medical record or documentation of the medical history detailing the member's medical condition and previous treatment results.
- Documentation by the prescriber that shows why other drug products have been ruled out as ineffective or unsafe for the member's medical condition.
- Documentation by the prescriber that shows why the non-rebated drug is the most appropriate and cost-effective drug to treat the member's medical condition.

If a PA request for a drug without a signed manufacturer rebate is approved, claims for drugs without a signed rebate agreement must be submitted on paper. Providers should complete and submit the [Noncompound Drug Claim \(F-13072 \(07/12\)\)](#) indicating the actual NDC of the drug with the [Pharmacy Special Handling Request \(F-13074 \(07/12\)\)](#) form.

If a PA request for a drug without a signed manufacturer rebate is denied, the service is considered noncovered.

Members Enrolled in SeniorCare (Levels 2b and 3)

PA is not available for drugs from manufacturers without a separate, signed SeniorCare rebate agreement for members in levels 2b and 3. PA requests submitted for drugs without a separate, signed SeniorCare rebate agreement for members in levels 2b and 3 will be returned to the providers unprocessed and the service will be noncovered. Members do not have appeal rights regarding returned PA requests for noncovered drugs.

Members Enrolled in the BadgerCare Plus Benchmark, the BadgerCare Plus Core Plan, and the BadgerCare Plus Basic Plan

PA is not available for drugs that are not included on the [BadgerCare Plus Benchmark Plan Product List](#), [BadgerCare Plus Core](#)

[Plan Product List](#), [BadgerCare Plus Core Plan Brand Name Drugs Quick Reference](#), and the [BadgerCare Plus Basic Plan Product List](#). PA requests submitted for noncovered drugs will be returned to providers unprocessed and the services will not be covered. Members do not have appeal rights regarding returned PA requests for noncovered drugs.

Drug Utilization Review System

The federal OBRA (Omnibus Budget Reconciliation Act of 1990) (42 CFR Parts 456.703 and 456.705) called for a DUR (Drug Utilization Review) program for all Medicaid-covered drugs to improve the quality and cost-effectiveness of member care. ForwardHealth's prospective DUR system assists pharmacy providers in screening certain drug categories for clinically important potential drug therapy problems before the prescription is dispensed to the member. The DUR system checks the member's entire drug history regardless of where the drug was dispensed or by whom it was prescribed.

Diagnoses from medical claims are used to build a medical profile for each member. The prospective DUR system uses this profile to determine whether or not a prescribed drug may be inappropriate or harmful to the member. It is very important that prescribers provide up-to-date medical diagnosis information about members on medical claims to ensure complete and accurate member profiles, particularly in cases of disease or pregnancy.

Note: The prospective DUR system does not dictate which drugs may be dispensed; prescribers and pharmacists must exercise professional judgment.

Prospective Drug Utilization Review's Impact on Prescribers

If a pharmacist receives an alert, a response is required before the drug can be dispensed to the member. This may require the pharmacist to contact the prescriber for additional information to determine if the prescription should be filled as written, modified, or cancelled. Prescribers should respond to inquiries, such as telephone calls or faxes, related to prescribed drugs from pharmacy providers.

Drugs with Three-Month Supply Requirement

ForwardHealth has identified a [list of three-month supply drugs](#):

- Certain drugs are required to be dispensed in a three-month supply.
- Additional drugs are allowed to be dispensed in a three-month supply.

Member Benefits

When it is appropriate for the member's medical condition, a three-month supply of a drug benefits the member in the following ways:

- Aiding compliance in taking prescribed generic, maintenance medications.
- Reducing the cost of member copayments.
- Requiring fewer trips to the pharmacy.
- Allowing the member to obtain a larger quantity of generic, maintenance drugs for chronic conditions (e.g., hypertension).

Prescribers are encouraged to write prescriptions for a three-month supply when appropriate for the member.

Prescription Quantity

A prescriber is required to indicate the appropriate quantity on the prescription to allow the dispensing provider to dispense the maintenance drug in a three-month supply. For example, if the prescription is written for "Hydrochlorothiazide 25 mg, take one tablet daily," the prescriber is required to indicate a quantity of 90 or 100 tablets on the prescription so the pharmacy provider can dispense a three-month supply. In certain instances, brand name drugs (e.g., oral contraceptives) may be dispensed in a three-

month supply.

Pharmacy providers are not required to contact prescribers to request a new prescription for a three-month supply if a prescription has been written as a one-month supply with multiple or as needed (i.e., PRN) refills.

ForwardHealth will not audit or recoup three-month supply claims if a pharmacy provider changes a prescription written as a one-month supply with refills as long as the total quantity dispensed per prescription does not exceed the total quantity authorized by the prescriber.

Prescription Mail Delivery

Current Wisconsin law permits Wisconsin Medicaid-enrolled retail pharmacies to deliver prescriptions to members via the mail. Wisconsin Medicaid-enrolled retail pharmacies may dispense and mail any prescription or OTC medication to a Medicaid fee-for-service member at no additional cost to the member or Wisconsin Medicaid.

Providers are encouraged to use the mail delivery option if requested by the member, particularly for prescriptions filled for a three-month supply.

Noncovered Drugs

The following drugs are not covered:

- Drugs that are identified by the FDA as LTE (less-than-effective) or identical, related, or similar to LTE drugs.
- Drugs identified on the Wisconsin Negative Formulary.
- Drugs manufactured by companies who have not signed the rebate agreement.
- Drugs to treat the condition of ED (Erectile Dysfunction). Examples of noncovered drugs for ED are Viagra® and Cialis®.

SeniorCare

[SeniorCare](#) is a prescription drug assistance program for Wisconsin residents who are 65 years of age or older and meet eligibility criteria. SeniorCare is modeled after Wisconsin Medicaid in terms of drug coverage and reimbursement, although there are a few differences. Unlike Medicaid, SeniorCare does not cover OTC drugs other than insulin.

Topic #4346

Tamper-Resistant Prescription Pad Requirement

Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 imposed a requirement on prescriptions paid for by Medicaid, SeniorCare, or BadgerCare fee-for-service. The law requires that all written or computer-generated prescriptions that are given to a patient to take to a pharmacy must be written or printed on tamper-resistant prescription pads or tamper-resistant computer paper. This requirement applies to prescriptions for both controlled and noncontrolled substances.

All other Medicaid policies and procedures regarding prescriptions continue to apply.

Required Features for Tamper-Resistant Prescription Pads or Computer Paper

To be considered tamper-resistant, federal law requires that prescription pads/paper contain all three of the following characteristics:

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Exclusions to Tamper-Resistant Prescription Pad Requirement

The following are exclusions to the tamper-resistant prescription pad requirement:

- Prescriptions faxed directly from the prescriber to the pharmacy.
- Prescriptions electronically transmitted directly from the prescriber to the pharmacy.
- Prescriptions telephoned directly from the prescriber to the pharmacy.
- Prescriptions provided to members in nursing facilities, ICF/IIDs (Intermediate Care Facilities for Individuals with Intellectual Disabilities), and other specified institutional and clinical settings to the extent that drugs are part of their overall rate. However, written prescriptions filled by a pharmacy outside the walls of the facility are subject to the tamper-resistant requirement.

72-Hour Grace Period

Prescriptions presented by patients on non-tamper-resistant pads or paper may be dispensed and considered compliant if the pharmacy receives a compliant prescription order within 72 hours.

Coordination of Benefits

The federal law imposing these new requirements applies even when ForwardHealth is the secondary payer.

Retroactive ForwardHealth Eligibility

If a patient becomes retroactively eligible for ForwardHealth, the federal law presumes that prescriptions retroactively dispensed were compliant. However, prospective refills will require a tamper-resistant prescription.

Penalty for Noncompliance

Payment made to the pharmacy for a claim corresponding to a noncompliant order may be recouped, in full, by ForwardHealth.

Provider Enrollment

Topic #15497

Advanced Practice Nurse Prescribers

APNPs (Advanced Practice Nurse Prescribers) with a psychiatric specialty and psychiatrists are the only mental health providers who can submit claims for psychotherapy services that include a medical E&M (evaluation and management) component. Additionally, APNPs with a psychiatric specialty are required to be separately enrolled in Medicaid as a nurse practitioner in order to be reimbursed for an E&M service.

Topic #899

CLIA Certification or Waiver

Congress implemented CLIA (Clinical Laboratory Improvement Amendment) to improve the quality and safety of laboratory services. CLIA requires *all* laboratories and providers that perform tests (including waived tests) for health assessment or for the diagnosis, prevention, or treatment of disease or health impairment to comply with specific federal quality standards. This requirement applies even if only a single test is being performed.

CLIA Enrollment

The federal CMS (Centers for Medicare and Medicaid Services) sends CLIA enrollment information to ForwardHealth. The enrollment information includes CLIA identification numbers for all current laboratory sites. ForwardHealth verifies that laboratories are CLIA certified before Medicaid grants enrollment.

CLIA Regulations

ForwardHealth complies with the following federal regulations as initially published and subsequently updated:

- Public Health Service Clinical Laboratory Improvement Amendments of 1988.
- Title 42 CFR Part 493, Laboratory Requirements.

Scope of CLIA

CLIA governs all laboratory operations including the following:

- Accreditation.
- Certification.
- Fees.
- Patient test management.
- Personnel qualifications.
- Proficiency testing.
- Quality assurance.
- Quality control.
- Records and information systems.
- Sanctions.

- Test methods, equipment, instrumentation, reagents, materials, supplies.
- Tests performed.

CLIA regulations apply to *all* providers who perform CLIA-monitored laboratory services, including, but not limited to, the following:

- Clinics.
- HealthCheck providers.
- Independent clinical laboratories.
- Nurse midwives.
- Nurse practitioners.
- Osteopaths.
- Physician assistants.
- Physicians.
- Rural health clinics.

CLIA Certification Types

The CMS regulations require providers to have a CLIA certificate that indicates the laboratory is qualified to perform a category of tests.

Clinics or groups with a single group billing certification, but multiple CLIA numbers for different laboratories, may wish to contact [Provider Services](#) to discuss various certification options. There are five types of CLIA certificates as defined by CMS:

1. *Certificate of Waiver*. This certificate is issued to a laboratory to perform only waived tests. The CMS Web site identifies the most current list of [waived procedures](#). BadgerCare Plus identifies allowable waived procedures in [maximum allowable fee schedules](#).
2. *Certificate for Provider-Performed Microscopy Procedures (PPMP)*. This certificate is issued to a laboratory in which a physician, mid-level practitioner, or dentist performs no tests other than the microscopy procedures. This certificate permits the laboratory to also perform waived tests. The CMS Web site identifies the most current list of [CLIA-allowable provider-performed microscopy procedures](#). BadgerCare Plus identifies allowable provider-performed microscopy procedures in fee schedules.
3. *Certificate of Registration*. This certificate is issued to a laboratory and enables the entity to conduct moderate- or high-complexity laboratory testing, or both, until the entity is determined by survey to be in compliance with CLIA regulations.
4. *Certificate of Compliance*. This certificate is issued to a laboratory after an inspection that finds the laboratory to be in compliance with all applicable CLIA requirements.
5. *Certificate of Accreditation*. This is a certificate that is issued to a laboratory on the basis of the laboratory's accreditation by an accreditation organization approved by CMS. The six major approved accreditation organizations are:
 - The Joint Commission.
 - CAP (College of American Pathologists).
 - COLA.
 - American Osteopathic Association.
 - American Association of Blood Banks.
 - ASHI (American Society of Histocompatibility and Immunogenetics).

Applying for CLIA Certification

Use the CMS 116 CLIA application to apply for program certificates. Providers may obtain CMS 116 forms from the [CMS Web site](#) or from the following address:

Division of Quality Assurance
Clinical Laboratory Section

1 W Wilson St
PO Box 2969
Madison WI 53701-2969

Providers Required to Report Changes

Providers are required to notify Provider Maintenance in writing within 30 days of any change(s) in ownership, name, location, or director. Also, providers are required to notify Provider Maintenance of changes in CLIA certificate types immediately and within six months when a specialty/subspecialty is added or deleted. Following is the address for providing written notification to Provider Maintenance:

ForwardHealth
Provider Maintenance
313 Blettner Blvd
Madison WI 53784

If a provider has a new certificate type to add to its certification information on file with ForwardHealth, the provider should send a copy of the new certificate to the above address. When a provider sends ForwardHealth a copy of a new CLIA certificate, the effective date on the certificate will become the effective date for CLIA certification on file with ForwardHealth.

Topic #3969

Categories of Enrollment

Wisconsin Medicaid enrolls providers in three billing categories. Each billing category has specific designated uses and restrictions. These categories include the following:

- Billing/rendering provider.
- Rendering-only provider.
- Billing-only provider (including group billing).

Providers should refer to the service-specific information in the Online Handbook or the Information for Specific Provider Types page on the [Provider Enrollment Information home page](#) to identify which category of enrollment is applicable.

Billing/Rendering Provider

Enrollment as a billing/rendering provider allows providers to identify themselves on claims (and other forms) as either the provider billing for the services or the provider rendering the services.

Rendering-Only Provider

Enrollment as a rendering-only provider is given to those providers who practice under the professional supervision of another provider (e.g., physician assistants). Providers with a rendering provider enrollment cannot submit claims to Wisconsin Medicaid directly, but they have reimbursement rates established for their provider type. Claims for services provided by a rendering provider must include the supervising provider or group provider as the billing provider.

Billing-Only Provider (Including Group Billing)

Enrollment as a billing-only provider is given to certain provider types when a separate rendering provider is required on claims.

Group Billing

Groups of individual practitioners are enrolled as billing-only providers as an accounting convenience. This allows the group to receive one reimbursement, one RA (Remittance Advice), and the 835 (835 Health Care Claim Payment/Advice) transaction for covered services rendered by individual practitioners within the group.

Providers may not have more than one group practice enrolled in Wisconsin Medicaid with the same ZIP+4 code address, NPI (National Provider Identifier), and taxonomy code combination. Provider group practices located at the same ZIP+4 code address are required to differentiate their enrollment using an NPI or taxonomy code that uniquely identifies each group practice.

Individual practitioners within group practices are required to be Medicaid-enrolled because these groups are required to identify the provider who rendered the service on claims. Claims indicating these group billing providers that are submitted without a rendering provider are denied.

Topic #1002

Durable Medical Equipment

To be reimbursed for dispensing DME (durable medical equipment), physicians are required to obtain separate [Medicaid enrollment](#) as a Medical Supply and Equipment Vendor. Physicians are required to comply with all federal laws and regulations, including the Stark statute on referrals.

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 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 initial enrollment and revalidation.
- Certain provider types are subject to an enrollment application fee of \$523. This fee has been federally mandated and may be adjusted annually. The fee is used to offset the cost of conducting screening activities.
- During the enrollment process, providers are required to provide additional information for persons with an ownership or controlling interest, managing employees, and agents. "Persons" in this instance may mean a person or a corporation.
- Providers are required to undergo revalidation every three to five years.
- Effective July 15, 2013, ordering and referring physicians or other professionals will be required to be enrolled as a participating Medicaid provider.
- Payment suspensions are imposed on providers based on a credible allegation of fraud.

ForwardHealth Implementation of Affordable Care Act Requirements to Date

Provider Screenings

Wisconsin Medicaid screens all enrolling providers to accommodate the ACA limited risk level screening requirements. Limited risk level screening activities include:

- Checking federal databases, which include:
 - The SSA (Social Security Administration's) Death Master File.
 - The NPES (National Plan and Provider Enumeration System).
 - OIG (Office of the Inspector General) LEIE (List of Excluded Individuals/Entities).
 - EPLS (The Excluded Parties List System).
 - MED (Medicare Exclusion Database).
- Verifying licenses are appropriate in accordance with state laws and that there are no current limitations on the license.

These screening activities are conducted on applicants, providers, and any person with an ownership or controlling interest or who is an agent or managing employee of the provider at the time of enrollment, on a monthly basis for enrolled providers, and at revalidation.

ForwardHealth will deny enrollment or terminate the enrollment of any provider where any person with a five percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years, or if invalid licensure information is found.

Additional Information Needed During Provider Enrollment

ForwardHealth collects some personal data information from persons with an ownership or controlling interest, agents, and managing employees. ForwardHealth will only use the provided information for provider enrollment. All information provided will be protected under the HIPAA (Health Insurance Portability and Accountability Act of 1996) privacy rule.

Providers are required to submit the following information at the time of enrollment and revalidation for their individual owners with a controlling interest:

- First and last name.
- Provider's SSNs (Social Security numbers).
- Dates of birth.
- Street address, city, state, and ZIP+4 code.

Providers are required to submit the following information at the time of enrollment and revalidation for their organizational owners with controlling interest:

- Legal business name.
- Tax identification number.
- Business street address, city, state, ZIP+4 code.

Providers are required to submit the following information at the time of enrollment and revalidation for their managing employees and agents:

- First and last name.
- Employees' and agents' SSNs.
- Dates of birth.
- Street address, city, state, and ZIP+4 code.

Topic #999

Express Enrollment for Pregnant Women Benefit

Physicians, physician assistants, nurse practitioners, and nurse midwives may become Medicaid-enrolled EE (express enrollment) providers. EE for Pregnant Women Benefit providers determine whether a pregnant woman may be eligible for BadgerCare Plus. The [EE for Pregnant Women Benefit](#) is a limited benefit category that allows an uninsured or underinsured (i.e., insured without prenatal coverage) pregnant woman to receive immediate pregnancy-related outpatient services while her application for full-benefit BadgerCare Plus is processed.

Topic #194

In-State Emergency Providers and Out-of-State Providers

ForwardHealth requires all in-state emergency providers and out-of-state providers who render services to BadgerCare Plus, Medicaid, or SeniorCare members to be [enrolled](#) in Wisconsin Medicaid. Information is available regarding the enrollment options for [in-state emergency providers](#) and [out-of-state providers](#).

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*. *Updates* are available for viewing and downloading on the [ForwardHealth Publications page](#).

Topic #865

Nurse Practitioners

Nurse practitioners who treat ForwardHealth members are required to be Medicaid-enrolled to receive reimbursement. This applies to nurse practitioners whose services are reimbursed under a physician's or clinic's NPI (National Provider Identifier), as well as to those who independently submit claims to Wisconsin Medicaid.

Medicaid services performed by nurse practitioners must be within the legal scope of practice as defined under the Wisconsin Board of Nursing licensure or certification. Services performed must be included in the individual nurse practitioner's protocols or a collaborative relationship with a physician as defined by the Board of Nursing.

Most advanced practice nurse prescribers who apply for Medicaid enrollment are enrolled as nurse practitioners (except for non-Master's degree-prepared nurse midwives and certified registered nurse anesthetists).

Pursuant to Board of Nursing [N 8.10\(7\)](#), Wis. Admin. Code, advanced practice nurse prescribers work in a collaborative relationship with a physician. (The collaborative relationship is defined as an advanced practice nurse prescriber works with a physician, "in each other's presence when necessary, to deliver health care services within the scope of the practitioner's professional expertise.")

Advanced practice nurse prescribers who dispense drugs in addition to prescribing them should obtain the appropriate Medicaid [pharmacy](#) publications. Providers may also call [Provider Services](#) for more information.

Medicaid-enrolled nurse practitioners who provide delegated medical care under the general supervision of a physician are required to be supervised only to the extent required pursuant to Board of Nursing [N 6.02\(7\)](#), Wis. Admin. Code. (Chapter N 6 defines general supervision as the regular coordination, direction, and inspection of the practice of another and does *not* require the physician to be on site.)

Note: Medicaid enrollment is not required for nurse practitioners working in family planning clinics or as psychiatric nurse practitioners/clinical nurse specialists. Family planning clinics and psychiatric nurse practitioners/clinical nurse specialists should refer to their service-specific areas of this Web site for information on covered services and related limitations.

Services provided by registered nurses who do not meet Medicaid nurse practitioner enrollment requirements may be reimbursed as services provided by [ancillary providers](#).

Protocols/Collaborative Agreements

Pursuant to N 8.10(7), Wis. Admin. Code, advanced practice nurse prescribers work in a collaborative relationship with a physician. The advanced practice nurse prescriber and the physician must document this relationship.

Pursuant to the requirements of [N 6.03\(2\)](#), Wis. Admin. Code, nurse practitioners may only perform those delegated medical acts for which there are protocols or written or verbal orders, and which the nurse practitioner is competent to perform based on his or her nursing education, training, or experience. Nurse practitioners may perform delegated medical acts under the general supervision or direction of a physician, podiatrist, dentist, or optometrist. In addition, nurse practitioners are required to consult with a physician, podiatrist, dentist, or optometrist in cases where the nurse practitioner knows or should know a delegated medical act may harm a patient.

For purposes of Medicaid enrollment, *no* service which is a medical act and is listed as an allowable physician service may be performed without a collaborative practice agreement as required for advanced practice nurse prescribers (pursuant to N 8.10(7), Wis. Admin. Code) or protocols, and written or verbal orders for other Medicaid-enrolled nurse practitioners pursuant to [N 6.03\(1\)](#), Wis. Admin. Code.

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, which can be accessed through their secure ForwardHealth Portal account.

Note: Providers are cautioned that any changes to their practice location on file with Wisconsin Medicaid may alter their ZIP+4 code information required on transactions. Providers may verify the ZIP+4 code for their address on the [U.S. Postal Service Web site](#).

Topic #14157

Provider Enrollment Information Home Page

ForwardHealth has consolidated all information providers will need for the enrollment process in one location on the ForwardHealth Portal. For information related to enrollment criteria and to complete online provider enrollment applications, providers should refer to the [Provider Enrollment Information home page](#).

The Provider Enrollment Information home page includes enrollment applications for each provider type and specialty eligible for enrollment with Wisconsin Medicaid. Prior to enrolling, providers may consult a provider enrollment criteria menu, which is a reference for each individual provider type detailing the information the provider may need to gather before beginning the enrollment process, including:

- Links to enrollment criteria for each provider type.
- Provider terms of reimbursement.
- Disclosure information.
- Category of enrollment.
- Additional documents needed (when applicable).

Providers will also have access to a list of links related to the enrollment process, including:

- General enrollment information.
- Regulations and forms.
- Provider type-specific enrollment information.
- In-state and out-of-state emergency enrollment information.
- Contact information.

Information regarding enrollment policy and billing instructions may still be found in the Online Handbook.

Topic #1931

Provider Type and Specialty Changes

Providers who want to add a provider type or make a change to their provider type should call [Provider Services](#).

Topic #1000

Temporary Enrollment for Family Planning Only Services

Providers qualified to make TE (temporary enrollment) decisions for pregnant women may also make TE decisions for women to receive routine contraceptive-related services and supplies immediately through TE for Family Planning Only Services for up to two months. Services and supplies covered under TE for Family Planning Only Services are the same as those covered under Family Planning Only Services and must be related to routine contraceptive management.

Topic #14317

Terminology to Know for Provider Enrollment

Due to the ACA (Affordable Care Act), ForwardHealth has adopted new terminology. The following table includes new terminology that will be useful to providers during the provider enrollment and revalidation processes. Providers may refer to the Medicaid rule 42 CFR s. 455.101 for more information.

New Terminology	Definition
Agent	Any person who has been delegated the authority to obligate or act on behalf of a provider.
Disclosing entity	A Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.
Federal health care programs	Federal health care programs include Medicare, Medicaid, Title XX, and Title XXI.
Other disclosing agent	Any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVII, or XX of the Act. This includes: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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. Owens 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	<ul style="list-style-type: none"> An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or, An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.
Re-enrollment	Re-enrollment of a provider whose Medicaid enrollment has ended for any reason other than sanctions or failure to revalidate may be re-enrolled as long as all licensure and enrollment requirements are met. If a provider's enrollment with Wisconsin Medicaid lapses for longer than one year, they will have to re-enroll as a "new" provider. Providers should note that when they re-enroll, application fees and screening activities may apply. Re-enrollment was formerly known as re-instate.

Revalidation	All enrolled providers are required to revalidate their enrollment information every three years to continue their participation with Wisconsin Medicaid. Revalidation was formerly known as recertification.
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Note: Providers should note that the CMS (Centers for Medicare and Medicaid Services) requires revalidation at least every five years. However, Wisconsin Medicaid will continue to revalidate providers every three years.

Provider Numbers

Topic #3421

Provider Identification

Health Care Providers

Health care providers are required to indicate an NPI (National Provider Identifier) on enrollment applications and electronic and paper transactions submitted to ForwardHealth.

The NPI is a 10-digit number obtained through the NPPES (National Plan and Provider Enumeration System).

Providers should ensure that they have obtained an appropriate NPI prior to beginning their enrollment application. There are two kinds of NPIs:

- Entity Type 1 NPIs are for individuals who provide health care, such as physicians, dentists, and chiropractors.
- Entity Type 2 NPIs are for organizations that provide health care, such as hospitals, group practices, pharmacies, and home health agencies.

It is possible for a provider to qualify for both Entity Type 1 and Entity Type 2 NPIs. For example, an individual physical therapist may also be the owner of a therapy group that is a corporation and have two Wisconsin Medicaid enrollments — one enrollment as an individual physical therapist and the other enrollment as the physical therapy group. A Type 1 NPI for the individual enrollment and a Type 2 NPI for the group enrollment are required.

NPIs and classifications may be viewed on the [NPPES Web site](#). The [CMS \(Centers for Medicare and Medicaid Services\) Web site](#) includes more information on Type 1 and Type 2 NPIs.

Health care providers who are federally required to have an NPI are responsible for obtaining the appropriate certification for their NPI.

Non-healthcare Providers

Non-healthcare providers, such as SMV (specialized medical vehicle) providers, personal care agencies, and blood banks, are exempt from federal NPI requirements. Providers exempt from federal NPI requirements are assigned a Medicaid provider number once their enrollment application is accepted; they are required to indicate this Medicaid provider number on electronic and paper transactions submitted to ForwardHealth.

Topic #733

Supervisor Changes for Nonbilling Providers

For supervisor changes, physician assistants are required to complete the [Declaration of Supervision for Nonbilling Providers \(F-01182 \(07/12\)\)](#) form.

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, which can be accessed through their secure ForwardHealth Portal account. The [Demographic Maintenance Tool User Guide](#) provides specific information on 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 Web site](#).

Provider Rights

Topic #208

A Comprehensive Overview of Provider Rights

Medicaid-enrolled providers have certain rights including, but not limited to, the following:

- Limiting the number of members they serve in a nondiscriminatory way.
- Ending participation in Wisconsin Medicaid.
- Applying for a discretionary waiver or variance of certain rules identified in Wisconsin Administrative Code.
- [Collecting payment from a member under limited circumstances](#).
- Refusing services to a member if the member refuses or fails to present a ForwardHealth identification card. However, possession of a ForwardHealth card does not guarantee enrollment (e.g., the member may not be enrolled, may be enrolled only for limited benefits, or the ForwardHealth card may be invalid). Providers may confirm the current enrollment of the member by using one of the [EVS \(Enrollment Verification System\) methods](#), including calling [Provider Services](#).

Topic #207

Ending Participation

Providers other than home health agencies and nursing facilities may terminate participation in ForwardHealth according to [DHS 106.05](#), Wis. Admin. Code.

Providers choosing to withdraw should promptly notify their members to give them ample time to find another provider.

When withdrawing, the provider is required to do the following:

- Provide a written notice of the decision at least 30 days in advance of the termination.
- Indicate the effective date of termination.

Providers will not receive reimbursement for nonemergency services provided on and after the effective date of termination. Voluntary termination notices can be sent to the following address:

ForwardHealth
 Provider Maintenance
 313 Blettner Blvd
 Madison WI 53784

If the provider fails to specify an effective date in the notice of termination, ForwardHealth may terminate the provider on the date the notice is received.

Topic #209

Hearing Requests

A provider who wishes to contest a DHS (Department of Health Services) action or inaction for which due process is required

under [s. 227](#), Wis. Stats., may request a hearing by writing to the DHA (Division of Hearings and Appeals).

A provider who wishes to contest the DHCAA's (Division of Health Care Access and Accountability) notice of intent to recover payment (e.g., to recoup for overpayments discovered in an audit by DHCAA) is required to request a hearing on the matter within the time period specified in the notice. The request, which must be in writing, should briefly summarize the provider's basis for contesting the DHS decision to withhold payment.

Refer to [DHS 106](#), Wis. Admin. Code, for detailed instructions on how to file an appeal.

If a timely request for a hearing is not received, the DHS may recover those amounts specified in its original notice from future amounts owed to the provider.

Note: Providers are not entitled to administrative hearings for billing disputes.

Topic #210

Limiting the Number of Members

If providers choose to limit the number of members they see, they cannot accept a member as a private-pay patient. Providers should instead refer the member to another ForwardHealth provider.

Persons applying for or receiving benefits are protected against discrimination based on race, color, national origin, sex, religion, age, disability, or association with a person with a disability.

Topic #206

Requesting Discretionary Waivers and Variances

In rare instances, a provider or member may apply for, and the DHCAA (Division of Health Care Access and Accountability) will consider applications for, a discretionary waiver or variance of certain rules in [DHS 102](#), [103](#), [104](#), [105](#), [107](#), and [108](#), Wis. Admin. Code. Rules that are not considered for a discretionary waiver or variance are included in [DHS 106.13](#), Wis. Admin. Code.

Waivers and variances are not available to permit coverage of services that are either expressly identified as noncovered or are not expressly mentioned in DHS 107, Wis. Admin. Code.

Requirements

A request for a waiver or variance may be made at any time; however, all applications must be made in writing to the DHCAA. All applications are required to specify the following:

- The rule from which the waiver or variance is requested.
- The time period for which the waiver or variance is requested.
- If the request is for a variance, the specific alternative action proposed by the provider.
- The reasons for the request.
- Justification that all requirements for a discretionary waiver or variance would be satisfied.

The DHCAA may also require additional information from the provider or the member prior to acting on the request.

Application

The DHCAA may grant a discretionary waiver or variance if it finds that all of the following requirements are met:

- The waiver or variance will not adversely affect the health, safety, or welfare of any member.
- Either the strict enforcement of a requirement would result in unreasonable hardship on the provider or on a member, or an alternative to a rule is in the interests of better care or management. An alternative to a rule would include a new concept, method, procedure or technique, new equipment, new personnel qualifications, or the implementation of a pilot project.
- The waiver or variance is consistent with all applicable state and federal statutes and federal regulations.
- Federal financial participation is available for all services under the waiver or variance, consistent with the Medicaid state plan, the federal CMS (Centers for Medicare and Medicaid Services), and other applicable federal program requirements.
- Services relating to the waiver or variance are medically necessary.

To apply for a discretionary waiver or variance, providers are required to send their application to the following address:

Division of Health Care Access and Accountability
Waivers and Variances
PO Box 309
Madison WI 53701-0309

Sanctions

Topic #211

Intermediate Sanctions

According to [DHS 106.08\(3\)](#), Wis. Admin. Code, the DHS (Department of Health Services) may impose intermediate sanctions on providers who violate certain requirements. Common examples of sanctions that the DHS may apply include the following:

- Review of the provider's claims before payment.
- Referral to the appropriate peer review organization, licensing authority, or accreditation organization.
- Restricting the provider's participation in BadgerCare Plus.
- Requiring the provider to correct deficiencies identified in a DHS audit.

Prior to imposing any alternative sanction under this section, the DHS will issue a written notice to the provider in accordance with [DHS 106.12](#), Wis. Admin. Code.

Any sanction imposed by the DHS may be appealed by the provider under DHS 106.12, Wis. Admin. Code. Providers may appeal a sanction by writing to the DHA (Division of Hearings and Appeals).

Topic #212

Involuntary Termination

The DHS (Department of Health Services) may suspend or terminate the Medicaid enrollment of any provider according to [DHS 106.06](#), Wis. Admin. Code.

The suspension or termination may occur if both of the following apply:

- The DHS finds that any of the grounds for provider termination are applicable.
- The suspension or termination will not deny members access to services.

Reasonable notice and an opportunity for a hearing within 15 days will be given to each provider whose enrollment is terminated by the DHS. Refer to [DHS 106.07](#), Wis. Admin. Code, for detailed information regarding possible sanctions.

In cases where Medicare enrollment is required as a condition of enrollment with Wisconsin Medicaid, termination from Medicare results in automatic termination from Wisconsin Medicaid.

Topic #213

Sanctions for Collecting Payment from Members

Under state and federal laws, if a provider inappropriately collects payment from an enrolled member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid enrollment. In addition, the provider may also be fined not more than \$25,000, or imprisoned not more than five years, or both, pursuant to 42 USC s. 1320a-7b(d) or [s. 49.49\(3m\)](#), Wis. Stats.

There may be narrow exceptions on when providers may [collect payment from members](#).

Topic #214

Withholding Payments

The DHS (Department of Health Services) may withhold full or partial Medicaid provider payments without prior notification if, as the result of any review or audit, the DHS finds reliable evidence of fraud or willful misrepresentation.

"Reliable evidence" of fraud or willful misrepresentation includes, but is not limited to, the filing of criminal charges by a prosecuting attorney against the provider or one of the provider's agents or employees.

The DHS is required to send the provider a written notice within five days of taking this action. The notice will generally set forth the allegations without necessarily disclosing specific information about the investigation.

Reimbursement

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Archive Date:01/02/2014

Reimbursement:Amounts

Topic #258

Acceptance of Payment

The amounts allowed as payment for covered services must be accepted as payment in full. Therefore, total payment for the service (i.e., any amount paid by other health insurance sources, any BadgerCare Plus or Medicaid copayment or spenddown amounts paid by the member, and any amount paid by BadgerCare Plus, Medicaid, or ADAP (Wisconsin AIDS Drug Assistance Program)) may not exceed the allowed amount. As a result, providers may not collect payment from a member, or authorized person acting on behalf of the member, for the difference between their usual and customary charge and the allowed amount for a service (i.e., balance billing).

Other health insurance payments may exceed the allowed amount if no additional payment is received from the member or BadgerCare Plus, Medicaid, or ADAP.

Topic #8277

Additional Reimbursement for Reporting Body Mass Index

ForwardHealth is collecting BMI (body mass index) data on children enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, or Medicaid to gather baseline information for future policy initiatives.

ForwardHealth will reimburse an additional \$10.00 to providers and clinics for reporting BMI on professional claims for routine office visits and preventive services for members two to 18 years old on the DOS (date of service).

Providers who are eligible to receive the additional reimbursement include the following:

- HealthCheck agencies.
- Nurse midwives.
- Nurse practitioners.
- Physician assistants.
- Physicians.

Reporting Body Mass Index on Claims

For the additional reimbursement, Current Procedural Terminology procedure code 3008F (Body mass index, documented) is required on the claim in addition to an office visit procedure code. A \$10.00 minimum is required to be billed for procedure code 3008F.

Procedure code 3008F must point to one of the following BMI diagnosis codes in the following table, as appropriate.

Code	Description
V85.51	Body Mass Index, pediatric, less than 5th percentile for age
V85.52	Body Mass Index, pediatric, 5th percentile to less than 85th percentile for age

V85.53	Body Mass Index, pediatric, 85th percentile to less than 95th percentile for age
V85.54	Body Mass Index, pediatric, greater than or equal to 95th percentile for age

Providers are required to [maintain records](#) that fully document the basis of charges upon which all claims for additional reimbursement payments are made.

Reimbursement

Providers are paid \$10.00 per billing provider, per child, per calendar year for reporting BMI for members in fee-for-service. Payments for reporting BMI will appear on the Remittance Advice under Explanation of Benefits 9944, "Pricing Adjustment - Incentive Pricing."

Topic #15337

Affordable Care Act Primary Care Rate Increase

Effective January 1, 2013, through December 31, 2014, certain providers who are identified as primary care practitioners may be eligible to receive a temporary rate increase for certain E&M (evaluation and management) and vaccine administration services. This increase is provided for under CFR 447.400(a), as instituted by the ACA (Affordable Care Act). The federally funded, temporary rate increase is authorized only for two calendar years, after which the rate will return to its previous level, assuming there is no additional federal action. Eligible services are those rendered by attested physicians on dates of service between January 1, 2013, and December 31, 2014.

Factors Determining When Rate Increase is Applied

The rate increase will be applied when eligible providers render eligible services to eligible members. Broad details on eligibility are described below.

Physician Eligibility

Physicians eligible for the rate increase are those who primarily practice as primary care providers (family practice, general internal medicine, or pediatric medicine) and are either:

- Certified with an eligible specialty or subspecialty by one of the certifying boards named in the Centers for Medicare and Medicaid Services Final Rule (CMS-2370-F). See the table below titled, "Specialties and Subspecialties Eligible for the Affordable Care Act Primary Care Rate Increase as Defined by the Three Certifying Boards."

Or

- A physician who submits claims with at least 60 percent of the procedure codes coming from the code group identified by the rule.

Specialties and Subspecialties Eligible for the Affordable Care Act Primary Care Rate Increase as Defined by the Three Certifying Boards	
American Board of Medical Specialties (ABMS)	
Specialties	Subspecialties
Family Medicine	Adolescent Medicine Geriatric Medicine Hospice and Palliative Medicine

	Sleep Medicine Sports Medicine
Internal Medicine	Adolescent Medicine Adult Congenital Heart Disease Advanced Heart Failure and Transplant Cardiology Cardiovascular Disease Clinical Cardiac Electrophysiology Critical Care Medicine Endocrinology, Diabetes, and Metabolism Gastroenterology Geriatric Medicine Hematology Hospice and Palliative Medicine Infectious Disease Interventional Cardiology Medical Oncology Nephrology Pulmonary Disease Rheumatology Sleep Medicine Sports Medicine Transplant Hepatology
Pediatrics	Adolescent Medicine Child Abuse Pediatrics Developmental-Behavioral Pediatrics Hospice and Palliative Medicine Medical Toxicology Neonatal-Perinatal Medicine Neurodevelopmental Disabilities Pediatric Cardiology Pediatric Critical Care Medicine Pediatric Emergency Medicine Pediatric Endocrinology Pediatric Gastroenterology Pediatric Hematology-Oncology Pediatric Infectious Diseases Pediatric Nephrology Pediatric Pulmonology Pediatric Rheumatology Pediatric Transplant Hepatology Sleep Medicine Sports Medicine
American Board of Physician Specialties (ABPS)	
Specialties	Subspecialties
Family Medicine Obstetrics	N/A
Internal Medicine	N/A
Family Practice	N/A
American Osteopathic Academy (AOA)	
Specialties	Subspecialties
Family Physicians	Addiction Medicine

	Adolescent and Young Adult Medicine Geriatric Medicine Sports Medicine Undersea and Hyperbaric Medicine Hospice and Palliative Medicine Sleep Medicine
Internal Medicine	Allergy/Immunology Cardiology Endocrinology Gastroenterology Hematology Hematology/Oncology Infectious Disease Pulmonary Disease Nephrology Oncology Rheumatology Addiction Medicine Critical Care Medicine Clinical Cardiac Electrophysiology Interventional Cardiology Geriatric Medicine Sports Medicine Undersea and Hyperbaric Medicine Hospice and Palliative Medicine Sleep Medicine
Pediatrics	Adolescent and Young Adult Medicine Neonatology Pediatric Allergy/Immunology Pediatric Endocrinology Pediatric Pulmonology Sports Medicine

Service Eligibility

The services identified by the rule as eligible are E&M services (procedure codes 99201-99499) and vaccine administration services. Services provided in federally qualified health centers, rural health clinics, and health departments are not eligible under the rule.

Member Eligibility

The majority of ForwardHealth members are enrolled in Wisconsin Medicaid, the BadgerCare Plus Benchmark Plan, or the BadgerCare Plus Standard Plan. Services provided to these members are eligible for the rate increase. There are some members enrolled in state-only and SCHIP (State Children's Health Insurance Program)-only funded programs. Services provided to these members are not eligible for the rate increase.

Eligibility for Advanced Practice Providers (Physician Assistants, Nurse Practitioners, Nurse Midwives)

APPs (advanced practice providers) who are physician assistants, nurse practitioners, or nurse midwives are also eligible for the primary care rate increase if they are supervised by an eligible physician. To be considered eligible in this case, the APP's practice

must be supervised by a physician who qualifies for the rate increase according to the physician eligibility criteria, and who has attested to this eligibility. APPs need to provide identification information for their supervisors; ForwardHealth will check supervisor attestation in order to determine APP eligibility. APPs who believe they are eligible for the rate increase should encourage their supervising providers to complete the attestation before they complete it in order to avoid a denial of the attestation.

Under the guidelines set out by the ACA Primary Care Rate Increase final rule and Wisconsin Administrative Code, the supervising physician is required to have direct involvement in the practice of the APP and to take responsibility for the patient care provided under his or her supervision in order for the APP to be eligible for the rate increase. Eligible APPs may still use their own NPIs (National Provider Identifiers) when submitting claims.

In implementing the ACA primary care rate increase rule, ForwardHealth expects that all APPs attesting for this increase follow the guidelines for supervisory protocol outlined by the Department of Safety and Professional Services in the Board of Nursing section, [s. N 6.03\(2\)](#), Wis. Admin. Code. Protocol for physician assistant supervision is contained in the Medical Examining Board section, [s. Med 8](#), Wis. Admin. Code.

Additionally, for purposes of AAP eligibility for the primary care rate increase, the final federal rule requires that each APP is supervised by a physician who accepts professional responsibility for the services that the APP provides. APPs fulfilling each of these requirements and who function as primary care providers will be eligible for the rate increase.

Criteria Provided in Attestation

To receive the primary care rate increase, providers are required to attest to their qualifications [online](#) via the ForwardHealth Portal.

Once the provider completes the attestation, ForwardHealth will check submitted information against the existing Medicaid provider enrollment file. Providers are notified in writing within 10 business days of submitting the attestation regarding the success of the attestation.

Beginning April 12, 2013, through December 31, 2013, providers may attest that they are eligible for services provided on and after January 1, 2013. However, beginning January 1, 2014, providers can attest that they are eligible only for services provided as of the date of their attestation.

If a provider experiences a change in practice or specialty focus that would either change the nature of his or her eligibility for the primary care rate increase or disqualify him or her from the primary care rate increase, that provider must notify ForwardHealth of this change. Examples of this include a lapse in board certification, change in claims volume, or, for APPs, change in supervising physician.

Provider attestations are effective through December 31, 2014, unless providers notify ForwardHealth that they are no longer eligible.

Providers who participate in large health systems and wish to delegate attestation to administrative staff may do so as long as the health system informs the provider that attestation has been submitted on his or her behalf. The health system must maintain a signed internal document from the provider stating that he or she is eligible and wishes to attest. These records may be requested if the provider's billing is audited.

Attestation Information for State-Contracted HMO Network Providers

Providers or designated clinic administration should attest directly to ForwardHealth in order to receive the rate increase. Providers should not submit attestation directly to HMOs; HMOs are not responsible for maintaining separate attestations or submitting attestations to ForwardHealth.

Reimbursement Schedules

Providers who attest by October 31, 2013, can expect to have claim adjustments and reimbursements initiated by December 31, 2013.

Providers who attest on and after October 31, 2013, and before December 31, 2013, are still able to attest as eligible backdated to as early as January 1, 2013. These providers can expect to have claim adjustments and reimbursements initiated on or after December 31, 2013.

Providers who attest on and after December 31, 2013, are only eligible for the rate increase beginning on the date of attestation forward. These providers should expect to have claims initiated in real time; each claim will be processed upon receipt by ForwardHealth.

Topic #647

Ancillary Providers

Wisconsin Medicaid covers counseling services (e.g., weight management, diabetic, smoking cessation, and prenatal services), coordination of care services, and delegated medical acts (e.g., giving injections or immunizations, checking medications, changing dressings) provided by ancillary providers if all of the following are true:

- The services are provided under the *direct, immediate, on-site* supervision of a physician.
- The services are pursuant to the physician's plan of care.
- The supervising physician has not also provided Medicaid reimbursable services during the same office or outpatient E&M (evaluation and management) visit.

Examples of ancillary providers include non-Medicaid enrollable health care professionals such as staff nurses, dietitian counselors, nutritionists, health educators, genetic counselors, and some nurse practitioners. (Nurse practitioners, nurse midwives, and anesthesiologists who are Medicaid enrolled should refer to their service-specific area for billing information.)

"On-site" means that the supervising physician is in the same building in which services are being provided and is immediately available for consultation or, in the case of emergencies, for direct intervention. The physician is not required to be in the same room as the ancillary provider, unless dictated by medical necessity and good medical practice.

Since ancillary providers are not Medicaid-eligible providers, claims for these services must be submitted under the supervising physician's NPI (National Provider Identifier) using the lowest appropriate level office or outpatient visit procedure code or other appropriate CPT (Current Procedural Terminology) code for the service performed. These services are not to be billed in addition to or combined with the physician service if the physician sees the patient during the same visit.

Topic #694

Billing Service and Clearinghouse Contracts

According to [DHS 106.03\(5\)\(c\)2](#), Wis. Admin. Code, contracts with outside billing services or clearinghouses may not be based on commission in which compensation for the service is dependent on reimbursement from BadgerCare Plus. This means compensation must be unrelated, directly or indirectly, to the amount of reimbursement or the number of claims and is not dependent upon the actual collection of payment.

Topic #8117

Electronic Funds Transfer

EFT (electronic funds transfer) allows ForwardHealth to directly deposit payments into a provider's designated bank account for a more efficient delivery of payments than the current process of mailing paper checks. EFT is secure, eliminates paper, and reduces the uncertainty of possible delays in mail delivery.

Only in-state and border-status providers who submit claims and MCOs (managed care organizations) are eligible to receive EFT payments.

Provider Exceptions

EFT payments are not available to the following providers:

- In-state emergency providers.
- Out-of-state providers.
- Out-of-country providers.
- SMV (specialized medical vehicle) providers during their provisional enrollment period.

Enrolling in Electronic Funds Transfer

A ForwardHealth Portal account is required to enroll into EFT as all enrollments must be completed via a secure Provider Portal account or a secure MCO Portal account. Paper enrollments are not accepted. A separate EFT enrollment is required for each financial payer a provider bills.

Providers who do not have a Portal account may [Request Portal Access](#) online. Providers may also call the [Portal Helpdesk](#) for assistance in requesting a Portal account.

The following guidelines apply to EFT enrollment:

- Only a Portal Administrator or a clerk that has been assigned the "EFT" role on the Portal may complete the EFT enrollment information.
- Organizations cannot revert back to receiving paper checks once enrolled in EFT.
- Organizations may change their EFT information at any time.
- Organizations will continue to receive their Remittance Advice as they do currently.

Refer to the Electronic Funds Transfer User Guide on the [Portal User Guides page](#) of the Portal for instructions and more information about EFT enrollment.

Providers will continue to receive payment via paper check until the enrollment process moves into "Active" status and the provider's ForwardHealth EFT enrollment is considered complete.

Recoupment and Reversals

Enrollment in EFT does not change the current process of recouping funds. Overpayments and recoupment of funds will continue to be conducted through the reduction of payments.

Note: Enrolling in EFT does not authorize ForwardHealth to make unauthorized debits to the provider's EFT account; however, in some instances an EFT reversal of payment may be necessary. For example, if the system generates a payment twice or the amount entered manually consists of an incorrect value (e.g., a decimal point is omitted creating a \$50,000 keyed value for a \$500 claim), a reversal will take place to correct the error and resend the correct transaction value. ForwardHealth will notify the designated EFT contact person of an EFT reversal if a payment is made in error due to a system processing or manual data entry

error.

Problem Resolution

If payment is not deposited into the designated EFT account according to the ForwardHealth payment cycle, providers should first check with their financial institution to confirm the payment was received. If the payment was not received, providers should then call [Provider Services](#) to resolve the issue and payment by paper check will be reinstated until the matter has been resolved.

Topic #897

Fee Schedules

[Maximum allowable fee](#) information is available on the ForwardHealth Portal in the following forms:

- Interactive fee schedule.
- Downloadable fee schedule in TXT (text) files.

Certain fee schedules are interactive. Interactive fee schedules provide coverage information as well as maximum allowable fees for all reimbursable procedure codes. The downloadable TXT files are free of charge and provide basic maximum allowable fee information for BadgerCare Plus by provider service area.

A provider may request a paper copy of a fee schedule by calling [Provider Services](#).

Providers may call Provider Services in the following cases:

- Internet access is not available.
- There is uncertainty as to which fee schedule should be used.
- The appropriate fee schedule cannot be found on the Portal.
- To determine coverage or maximum allowable fee of procedure codes not appearing on a fee schedule.

Topic #648

Health Professional Shortage Areas

Enhanced reimbursement is provided to Medicaid-enrolled primary care providers and emergency medicine providers for selected services when one or both of the following apply:

- The rendering or billing provider is located in a [HPSA \(Health Professional Shortage Area\)-eligible ZIP code](#).
- The member has a residential address (according to enrollment records) within a HPSA-eligible ZIP code.

Primary care providers and emergency medicine providers include the following:

- Physicians with specialties of general practice, obstetrics and gynecology, family practice, internal medicine, or pediatrics.
- Physician assistants.
- Nurse practitioners.
- Nurse midwives.

Standard enhanced reimbursement for HPSA-eligible primary care procedures is an additional 20 percent of the physician maximum allowable fee. The enhanced reimbursement for HPSA-eligible obstetrical procedures is an additional 50 percent of the physician maximum allowable fee.

Health Professional Shortage Area-Eligible Procedure Codes

Providers may submit claims with HPSA modifier "AQ" (Physician providing a service in a HPSA). While the modifier is defined for physicians only, any Medicaid HPSA-eligible provider may use them with the following procedure codes.

Category	Procedure Code(s)
E&M (evaluation and management) Services* New Patient	99201, 99202, 99203, 99204, 99205
Established Patient	99211, 99212, 99213, 99214, 99215
Emergency Department	99281, 99282, 99283, 99284, 99285
Newborn Care	99460, 99461, 99462, 99463, 99464, 99465
Preventive Medicine	94772, 96110, 99386, 99387, 99396, 99397
Obstetric Care	59020, 59025, 59050, 59300, 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622, 59812, 59820, 59821, 59830, 76801, 76802, 76805, 76810, 76811, 76815, 76816, 76818, 76819, 76825, 76826, 76827, 76828 99204 + modifier "TH" (for initial antepartum care visit)** 99213 + modifier "TH" (for two to three antepartum care visits, after initial visit)**
Vaccines	90702, 90704, 90705, 90706, 90707, 90708, 90712, 90713, 90718, 90744

*Providers should not submit claims with HPSA modifier "AQ" and modifier "TJ" (Program group, child and/or adolescent) for procedure codes 99201-99215 and 99281-99285. Providers should use only a HPSA modifier, when applicable. Wisconsin Medicaid will determine the member's age and determine the proper HPSA reimbursement for these procedure codes.

**Providers are required to use modifier "TH" (Obstetrical treatment/services, prenatal or postpartum) with procedure codes 99204 and 99213 only when those codes are used to indicate the first three antepartum care visits. Providers are required to use both the "TH" modifier and HPSA modifier "AQ" when these prenatal services are HPSA eligible for appropriate reimbursement.

Modifier

To obtain the HPSA-enhanced reimbursement, indicate modifier "AQ" along with the appropriate procedure code on the claim.

Medicare HPSA policy differs from Wisconsin Medicaid's HPSA policy in many ways. Medicaid covers more services than *Medicare*, allows a broader range of providers to receive the incentive payment, pays a higher bonus, and defines HPSA differently than *Medicare*. Most importantly, Wisconsin Medicaid pays the enhanced reimbursement to physicians, physician assistants, nurse practitioners, and nurse midwives while *Medicare* pays the HPSA incentive payment only to physicians.

For these reasons, Medicare crossover claims that are eligible for the Medicaid HPSA incentive payment may not automatically be forwarded to ForwardHealth from *Medicare*. Providers may have to submit these claims directly to ForwardHealth.

Antepartum Care Visits Performed in a Health Professional Shortage Area

If only the first three antepartum care visits are being billed and the service is HPSA eligible, the provider should bill the

appropriate E&M procedure code (99204 or 99213) with the "TH" modifier (Obstetrical treatment/services, prenatal or postpartum) listed first and the HPSA modifier listed second. Claims without modifier "TH" will result in lower reimbursement.

Pediatric Services Performed in a Health Professional Shortage Area

Reimbursement for eligible procedure codes with the HPSA modifier automatically includes the pediatric incentive payment, when applicable, since the incentive payment is based on the age of the member. Do not submit claims with the "TJ" modifier (Program group, child and/or adolescent) in addition to the HPSA modifier for the same procedure code. The "TJ" modifier may be used when submitting claims for eligible services in situations that do not qualify for HPSA-enhanced reimbursement. Pediatric services include office and other outpatient services (procedure codes 99201-99215) and emergency department services (procedure codes 99281-99285) for members 18 years and younger.

HealthCheck Services Not Eligible for Health Professional Shortage Area Incentive Payment

Procedure codes 99381-99385 and 99391-99395 are *not* eligible for HPSA bonuses, regardless of the billing or rendering provider's or member's location, since reimbursement for these procedure codes includes enhanced reimbursement for HealthCheck services.

Claims Submitted Inappropriately for Health Professional Shortage Area Incentive Payment

Providers who submit claims for the HPSA-enhanced reimbursement inappropriately are reimbursed the lesser of the provider's usual and customary fee or the maximum allowable fee, assuming that all other ForwardHealth policies are followed. The enhanced reimbursement amount is not paid when the HPSA modifier is submitted but the provider or member is not eligible for HPSA designation.

Health Professional Shortage Areas

Note: The county is listed for information purposes only. Not all ZIP codes in a county may be included in the HPSA.

Name	County	ZIP Codes
Adams County	Adams	Entire county: 53910, 53920, 53927, 53934, 53936, 53952, 53964, 53965, 54457, 54613, 54921, 54930, 54943, 54966
Augusta/Osseo	Eau Claire	54722, 54741, 54758, 54770
	Jackson	54635, 54741, 54758
	Trempealeau	54758, 54770
Baldwin	St. Croix	54002, 54013, 54015, 54017, 54026, 54027, 54028, 54749, 54767
	Dunn	54749, 54751
Bayfield	Ashland	54850
	Bayfield	54814, 54827, 54844, 54891
Beloit	Rock	53511, 53512
Boscobel	Crawford	53805, 53826, 53831, 54657
	Grant	53518, 53573, 53801, 53804, 53805, 53809, 53816, 53821, 53827
	Richland	53518, 53573
Burnett County	Burnett	Entire county: 54801, 54813, 54830, 54837, 54840, 54845, 54853, 54871, 54872, 54893
Central Trempealeau	Trempealeau	54616, 54747, 54760, 54773
Chetek/Colfax	Barron	54004, 54728, 54733, 54757, 54762, 54812, 54889, 54895
	Dunn	54005, 54725, 54730, 54734, 54749, 54751, 54757, 54763, 54772
Chilton/New Holstein/Brillion	Calumet	53014, 53042, 53049, 53061, 53062, 54110, 54129, 54130
Clark County	Clark	Entire county: 54405, 54420, 54421, 54422, 54425, 54436, 54437, 54446, 54456, 54460, 54466, 54479, 54488, 54493, 54498, 54746, 54754, 54768, 54771
Clintonville/Marion	Outagamie	54106, 54170, 54922
	Shawano	54928, 54929, 54950
	Waupaca	54922, 54929, 54949, 54950
Coon Valley/Chaseburg	La Crosse	54619, 54623, 54667
	Vernon	54621, 54623, 54667
Darlington/Schullsburg	Green	53504, 53516
	Lafayette	53504, 53516, 53530, 53541, 53565, 53586, 53587
Durand	Buffalo	54736
	Dunn	54736, 54737, 54739, 54740, 54751, 54755
	Pepin	54721, 54736, 54759, 54769
	Pierce	54740, 54750, 54761, 54767
Eastern Marinette/Southern Menomonie	Marinette	54143, 54157, 54159, 54177

Elcho	Langlade	54424, 54428, 54435, 54462, 54485
	Oneida	54435, 54463
Florence County	Florence	Entire county: 54103, 54120, 54121, 54151, 54542
Forest County	Forest	Entire county: 54103, 54104, 54465, 54511, 54520, 54541, 54542, 54562, 54566
Frederic/Luck	Polk	54829, 54837, 54853
Galesville/Trempealeau	Trempealeau	54612, 54625, 54627, 54630, 54661
Hayward/Radisson	Bayfield	54517, 54821, 54832, 54839, 54873
	Sawyer	54817, 54835, 54843, 54862, 54867, 54876, 54896
	Washburn	54843, 54875, 54876
Hillsboro	Juneau	53929, 53968
	Monroe	53929, 54638, 54648, 54651, 54670
	Richland	53924, 53941, 54634
	Sauk	53968
	Vernon	53929, 53968, 54634, 54638, 54639, 54651
Hurley/Mercer	Iron	54534, 54536, 54545, 54547, 54550, 54559
Kenosha	Kenosha	53140, 53142, 53143, 53144
Kewaunee City/Algoma	Kewaunee	54201, 54205, 54216, 54217
Lancaster/Fennimore	Grant	53569, 53802, 53804, 53806, 53809, 53810, 53813, 53820, 53825
Land O'Lakes/Presque Isle	Vilas	54540, 54547, 54557
Markesan/Kingston	Green Lake	53923, 53926, 53939, 53946, 53947, 53949
Marquette County	Marquette	Entire county: 53920, 53926, 53930, 53949, 53952, 53953, 53954, 54960, 53964, 54982
Menominee County	Menominee	Entire county: 54135, 54150, 54416
Milwaukee	Milwaukee	53203, 53204, 53205, 53206, 53208, 53209, 53210, 53212, 53215, 53216, 53218, 53233
Minong/Solon Springs	Douglas	54820, 54830, 54838, 54849, 54859, 54873
	Washburn	54859, 54875, 54888
Mondovi	Buffalo	54610, 54622, 54736, 54747, 54755
	Pepin	54755
Mountain/White Lake	Langlade	54430, 54465, 54491
	Oconto	54112, 54114, 54138, 54149, 54161, 54174, 54175, 54491
Oconto/Oconto Falls	Oconto	54101, 54124, 54139, 54141, 54153, 54154, 54171, 54174
	Shawano	54127
Platteville/Cuba City	Grant	53554, 53807, 53811, 53818, 53820
	Iowa	53554, 53580
	Lafayette	53510, 53803, 53807, 53811, 53818
Portage/Pardeeville	Columbia	53901, 53911, 53923, 53928, 53932, 53935, 53954, 53955, 53956, 53960, 53969
	Dodge	53956, 53957

Price/Mellen	Ashland	54514, 54527, 54546
	Iron	54552
	Price	Entire county: 54459, 54513, 54514, 54515, 54524, 54530, 54537, 54552, 54555, 54556, 54564
Pulaski	Brown	54162
	Shawano	54162, 54165
	Oconto	54162
Rusk County	Rusk	Entire county: 54526, 54530, 54563, 54728, 54731, 54745, 54757, 54766, 54817, 54819, 54835, 54848, 54868, 54895
Sister Bay/Washington Island	Door	54202, 54210, 54211, 54212, 54234, 54246
Sparta	Monroe	54615, 54619, 54648, 54656
Spooner/Shell Lake	Washburn	54801, 54813, 54817, 54870, 54871, 54875, 54888
Spring Green/Plain	Richland	53556
	Sauk	53556, 53577, 53578, 53583, 53588, 53937, 53943, 53951
Stanley/Cornell	Chippewa	54726, 54727, 54732, 54745, 54757, 54766, 54768
	Eau Claire	54722, 54726, 54742, 54768
Sturgeon Bay	Door	54201, 54202, 54204, 54209, 54213, 54217, 54235
Taylor County	Taylor	Entire county: 54422, 54425, 54433, 54434, 54439, 54447, 54451, 54460, 54470, 54480, 54490, 54498, 54766, 54768, 54771
Tigerton/Biramwood	Marathon	54408, 54414, 54427, 54429, 54440, 54499
	Shawano	54409, 54414, 54416, 54427, 54450, 54486, 54499
	Waupaca	54486, 54926, 54945
Tomahawk	Lincoln	54435, 54442, 54487, 54501, 54564
	Oneida	54487, 54529, 54564
Wausau, City of	Marathon	54401, 54403
Waushara	Waushara	54909, 54923, 54930, 54940, 54943, 54960, 54965, 54966, 54967, 54970, 54981, 54982, 54984
Western Marinette	Marinette	54102, 54104, 54112, 54114, 54119, 54125, 54151, 54156, 54159, 54161, 54177

Topic #3510

HealthCheck Services

Wisconsin Medicaid provides enhanced reimbursement for comprehensive health screenings for members under age 21 when those screenings are billed as HealthCheck services (CPT (Current Procedural Terminology) procedure codes 99381-99385 and 99391-99395).

Topic #260

Maximum Allowable Fees

Maximum allowable fees are established for most covered services. Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

Providers are reimbursed at the lesser of their billed amount and the maximum allowable fee for the procedure.

Topic #649

Maximum Daily Reimbursement

ForwardHealth reimbursement for services performed on the same DOS (date of service) for the same member by the same rendering provider is limited to \$2,331.37 for services rendered by the following providers:

- Anesthesiologists.
- Anesthesiologist Assistants.
- Certified Registered Nurse Anesthetists.
- Dentists.
- Nurse Midwives.
- Nurse Practitioners.
- Oral Surgeons.
- Physician Assistants.
- Physicians.
- Podiatrists.

The maximum daily reimbursement amount does not apply to physician-administered drugs and DME (durable medical equipment).

ForwardHealth remittance information will indicate when the maximum daily reimbursement amount has been met.

Requests to Exceed Maximum Daily Reimbursement Limit

Providers may request additional reimbursement to exceed the maximum daily reimbursement limit when both of the following criteria are met:

1. A surgery exceeds 6 hours or anesthesia exceeds 7.5 hours.
2. The Medicaid-allowed amount for the services meets or exceeds the maximum daily reimbursement limit.

Submitting Supporting Documentation

To request reimbursement in excess of the maximum daily reimbursement limit, providers are required to submit the following information on the claim:

- In the Notes field, indicate "request for additional reimbursement for surgery in excess of 6 hours," or "request for additional reimbursement for anesthesia services in excess of 7.5 hours."
- Attach supporting documentation to the claim that clearly indicates the length of the surgery or the length of the anesthesia services, such as a post-operative report.

Providers are reminded of the following options for providing supporting documentation along with a claim:

- On paper with supporting documentation submitted on paper.
- Electronically using DDE (Direct Data Entry) through the Portal, PES (Provider Electronic Solutions) transactions, or 837 Health Care Claim electronic transactions. For more information, refer to the [Portal User Guides](#), the [PES User Manual](#), or the [ForwardHealth Companion Guides](#).
- Electronically with an indication that supporting documentation will be submitted separately on paper. For more information, refer to the [ForwardHealth Companion Guides](#).

Topic #866

Nurse Practitioners

Nurse practitioners are reimbursed the lesser of the nurse practitioner's usual and customary charge for a service or the physician's maximum allowable fee for the procedure. Nurse practitioners use the physician maximum allowable fee schedule.

Topic #650

Pediatric Services

Wisconsin Medicaid provides an enhanced reimbursement rate for office and other outpatient services (CPT (Current Procedural Terminology) codes 99201-99215) and emergency department services (CPT codes 99281-99285) for members 18 years of age and younger. The enhanced reimbursement rates are indicated on the physician services [maximum allowable fee schedule](#).

To obtain the enhanced reimbursement for members under 18 years old, indicate the applicable procedure code and modifier "TJ" (Program group, child and/or adolescent) on the claim.

Topic #4385

Pharmacy Services and Some Drug-Related Supplies

Pharmacy services and some [drug-related supplies](#) for managed care members are reimbursed by fee-for-service.

The following provider-administered drugs and related administration codes are reimbursed by fee-for-service, not a member's MCO (managed care organization), for members enrolled in BadgerCare Plus HMOs, Medicaid SSI (Supplemental Security Income) HMOs, and most special managed care programs if the service is covered by BadgerCare Plus and Medicaid:

- All "J" codes.
- Drug-related "Q" codes.
- A limited number of related [administration codes](#).

For members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, claims for these services should be submitted to BadgerCare Plus and Medicaid fee-for-service.

MCOs are responsible for reimbursing providers for all other provider-administered drugs, such as drug claims submitted with a CPT (Current Procedural Terminology) code, such as CPT code 90378 (Respiratory syncytial virus immune globulin [RSV-IgIM], for intramuscular use, 50 mg, each).

Prescription drugs and related services and provider-administered drugs for members enrolled in the PACE (Program of All-Inclusive Care for the Elderly) and the Family Care Partnership are provided and reimbursed by the special managed care program.

Claims

Claims for drug-related supplies should be submitted with the appropriate HCPCS (Healthcare Common Procedure Coding System) procedure code indicated.

Topic #651

Physician Assistants

Wisconsin Medicaid generally reimburses physician assistants 90 percent of the payment allowed for the physician who would have otherwise performed the service. Physician assistants are paid 100 percent of the physician's maximum fee for HealthCheck screens, injections, immunizations, lab handling fees, and select diagnostic procedures.

Topic #652

Physicians

Wisconsin Medicaid reimburses physicians the lesser of the physician's billed amount for a service or Wisconsin Medicaid's maximum allowable fee.

Topic #553

Psychiatric and Substance Abuse Services

To be reimbursed for psychiatric services (CPT (Current Procedural Terminology) codes 90785-90853, 90865-90899), physicians are required to be certified as a psychiatrist pursuant to [DHS 105.22\(1\)\(a\)](#), Wis. Admin. Code.

Any Medicaid-enrolled physician may be reimbursed for substance abuse services.

Topic #7777

Reimbursement Rates for Professional Services

For most professional services, ForwardHealth reimburses no more than Medicare rates. However, for select professional services, the rate for the service is greater than the Medicare rate when provided to members 18 years of age and younger on the date of service.

Providers should refer to the Medicaid [maximum allowable fee schedule](#) on the ForwardHealth Portal for current reimbursement rates.

Topic #13297

Reimbursement for Office-Based Services Provided in a Hospital or an Ambulatory Surgery Center

ForwardHealth reduces reimbursement to physicians and other professional service providers for services that are typically provided in an office-based setting when those services are instead provided in a hospital (POS (place of service) code 21 or 22) or an ASC (ambulatory surgery center) (POS code 24). The reduced reimbursement is intended to account for the lower overhead costs typically realized by physicians and other professional services providers when services are provided in a hospital or an ASC.

Refer to the [table](#) below for the affected codes. The reduced reimbursement for these services when provided in a hospital or an ASC equals 80 percent of maximum allowable fees.

Affected services are reimbursed at the full maximum allowable fee when provided in an allowable POS other than 21, 22, or 24.

For select services (identified on the table by an asterisk), reimbursement reductions apply only for members who are 19 years of age or older on the DOS (date of service). For these select services, providers are reimbursed at the full maximum allowable fee when the service is rendered to members who are 18 years of age or younger on the DOS, regardless of POS.

10021	10022	10040	10060	10061	10080	10081	10120	10121	10140
10160	11000	11001	11042	11055	11056	11057	11100	11101	11200
11201	11300	11301	11302	11303	11305	11306	11307	11308	11310
11311	11312	11313	11400	11401	11402	11403	11404	11406	11420
11421	11422	11423	11424	11426	11440	11441	11442	11443	11444
11446	11600	11601	11602	11603	11604	11606	11620	11621	11622
11623	11624	11626	11640	11641	11642	11643	11644	11646	11719
11720	11721	11730	11732	11740	11750	11752	11755	11765	11900
11901	11950	11951	11952	11954	11971	11975	11976	11977	11980
11981	11982	11983	12020	12021	15851	16000	16020	16025	16030
17000	17003	17004	17106	17107	17108	17110	17111	17250	17260
17261	17262	17263	17264	17266	17270	17271	17272	17273	17274
17276	17280	17281	17282	17283	17284	17286	17311	17312	17313
17314	17315	17340	17360	19000	19001	19030	19100	19101	19102
19103	20526	20550	20551	20552	20553	20600	20605	20610	20612
20615	21073	21076	21077	21079	21080	21081	21082	21083	21084
21085	21086	21087	21088	23350	23500	23505	23520	23525	23540
23545	23570	23575	23620	23625	24500	24505	24530	24535	24560
24565	24576	24577	24640	24650	24655	24670	24675	25246	25500
25505	25520	25530	25535	25560	25565	25600	25605	25622	25624
25630	25635	25650	25675	26010	26011	26600	26605	26641	26645
26670	26675	26700	26705	26720	26725	26740	26742	26750	26755
26770	26775	27093	27095	27096	27220	27230	27246	27256	27370
27500	27501	27508	27516	27520	27530	27532	27538	27550	27560
27648	27656	27750	27752	27760	27762	27767	27780	27781	27786
27788	27808	27810	27816	27818	27824	27825	27830	28400	28405
28430	28435	28450	28455	28470	28475	28490	28495	28510	28515
28530	28540	28545	28570	28575	28600	28605	28630	28635	28660
28665	29000	29010	29015	29020	29025	29035	29040	29044	29046
29049	29055	29058	29065	29075	29085	29086	29105	29125	29126
29130	29131	29200	29240	29260	29280	29305	29325	29345	29355

29358	29365	29405	29425	29435	29440	29445	29450	29505	29515
29520	29530	29540	29550	29580	29581	29700	29705	29710	29715
29720	29730	29740	29750	30300	30801	30802	30901	30903	30905
30906	31000	31002	31231	31233	31235	31237	31238	31295	31296
31297	31505	31510	31511	31512	31515	31525	31570	31575	31576
31577	31578	31579	31615	36000	36147	36148	36400	36405	36406
36410	36416	36470	36471	36475	36476	36478	36479	36600	37765
37766	38220	38221	40490	40500	40510	40520	40530	40650	40652
40654	40800	40801	40804	40805	40806	40808	40810	40812	40814
40816	40818	40819	40820	40830	40831	40840	40842	40843	40844
40845	41000	41005	41006	41007	41008	41009	41010	41015	41016
41017	41018	41100	41105	41108	41110	41112	41113	41115	41116
42100	42400	42405	42650	42660	42700	42720	42725	42800	42802
42804	42806	42808	42809	45300	45303	45305	45307	45308	45309
45315	45317	45320	45321	45327	46083	46220	46221	46320	46600
46604	46606	46608	46610	46611	46612	46614	46615	46900	46910
46916	46917	46922	46924	46930	46940	46942	46945	46946	51100
51101	51102	51600	51610	51700	51701	51702	51703	51705	51710
51715	51720	51725	51726	51727	51728	51729	51736	51741	51784
51785	51792	51797	51798	52000	52001	52005	52007	52010	52204
52214	52224	52265	52270	52275	52281	52283	52285	52310	52315
53600	53601	53620	53621	53660	53661	53850	53852	53855	53860
54000	54001	54050	54055	54056	54057	54060	54065	54100	54105
54200	54450	55200	55250	55450	55700	56405	56420	56440	56441
56501	56515	56605	56606	56820	56821	57061	57065	57100	57105
57160	57170	57180	57420	57421	57452	57454	57455	57456	57460
57461	57500	57505	57510	57511	57513	57520	57522	57800	58100
58110	58300	58301	58340	58353	58356	58555	58558	58562	58563
58565	59000	59015	59020	59025	59425	59426	59430	60000	60100
60300	62280	62281	62282	62284	62290	62291	62292	62294	62310
62311	62367	62368	64402	64405	64408	64410	64412	64413	64417
64418	64420	64421	64430	64435	64445	64450	64455	64479	64480
64483	64484	64490	64491	64492	64493	64494	64495	64505	64508
64530	64550	64553	64555	64560	64561	64565	64566	64600	64605
64610	64611	64612	64613	64614	64620	64622	64623	64626	64627

64630	64632	64640	64650	64653	64680	64681	65205	65210	65220
65222	65270	65272	65275	65286	65400	65410	65420	65426	65430
65435	65436	65450	65600	65772	65778	65779	65800	65815	65855
65860	66020	66030	66130	66250	66700	66710	66720	66740	66761
66762	66770	66821	67025	67028	67101	67105	67110	67120	67141
67145	67208	67210	67220	67221	67225	67227	67228	67500	67505
67515	67700	67710	67715	67800	67801	67805	67810	67820	67825
67830	67840	67850	67875	67880	67882	67900	67901	67903	67904
67908	67909	67912	67914	67915	67916	67917	67921	67922	67923
67924	67930	67935	67938	67950	67961	67966	68020	68040	68100
68110	68115	68130	68135	68200	68320	68330	68340	68360	68400
68420	68440	68510	68530	68705	68760	68761	68801	68810	68815
68816	68840	68850	69000	69005	69020	69100	69105	69110	69145
69200	69210	69220	69222	69300	69400	69401	69405	69420	69433
69540	90911	92612	92613	92614	92615	92616	92617	92640	93000
93005	93015	93017	93040	93041	93224	93225	93226	93227	93228
93229	93268	93270	93271	93272	93278	93279	93280	93281	93282
93283	93284	93285	93288	93289	93290	93291	93292	93293	93294
93295	93296	93297	93298	93299	93303	93304	93306	93307	93308
93320	93321	93325	93350	93351	93352	93880	93882	93922	93923
93924	93925	93926	93930	93931	93965	93970	93971	93975	93976
93978	93979	93980	93981	93982	93990	94010	94060	94070	94150
94200	94240	94250	94260	94350	94360	94370	94375	94400	94450
94452	94453	94660	94680	94681	94690	94720	94725	94750	94760
94770	95004	95012	95024	95027	95028	95044	95052	95056	95060
95065	95070	95071	95800	95801	95805	95806	95807	95808	95810
95811	95812	95813	95816	95819	95830	95831	95832	95833	95834
95851	95852	95857	95860	95861	95863	95864	95865	95866	95867
95868	95869	95870	95872	95873	95874	95875	95905	95921	95922
95923	95925	95926	95927	95930	95933	95951	95953	95956	95957
95970	95971	95972	95973	95974	95975	95978	95979	95980	95981
95982	95990	95991	95992	96000	96001	96002	96003	96004	96101
96102	96103	96105	96110	96111	96116	96118	96119	96120	96125
96450	96542	97597	97598	97605	97606	97750	97760	97762	98925

98926	98927	98928	98929	99170	99173	99201*	99202*	99203*	99204*
99205*	99211*	99212*	99213*	99214*	99215*	99241*	99242*	99243*	99244*
99245*	99354	99355	99381	99382	99383	99384	99385	99386	99387
99391	99392	99393	99394	99395	99396	99397	G0101	G0102	G0104
G0365									

* For these select procedure codes, reimbursement reductions apply only for members who are 19 years of age or older on the DOS.

Topic #653

Residents

Wisconsin Medicaid reimburses residents for physician services when:

- The resident is fully licensed to practice medicine and has obtained an NPI (National Provider Identifier).
- The service can be separately identified from those services that are required as part of the training program.
- The resident is operating independently and not under the direct supervision of a physician.
- The service is provided in a clinic, an outpatient hospital, or emergency department setting.

The reimbursement for residents is identical to other licensed physicians.

Topic #655

Supervising Physicians of Interns and Residents

Wisconsin Medicaid reimburses supervising physicians in a teaching setting for the services provided by interns and residents, if those services are supervised, provided as part of the training program, and billed under the supervising physician's NPI (National Provider Identifier). The supervising physician must provide personal and identifiable direction to interns or residents who are participating in the care of the member. This direction includes any or all of the following:

- Reviewing the member's medical history or physical examination.
- Personally examining the member within a reasonable period after admission.
- Confirming or revising diagnoses.
- Determining the course of treatment to be followed.
- Making frequent review of the member's progress.

The notes must indicate that the supervising physician personally reviewed the member's medical history, performed a physical and/or psychiatric examination, confirmed or revised the diagnosis, and discharged the member.

Topic #656

Surgical Procedures

Surgical procedures performed by the same physician, for the same member, on the same DOS (date of service) must be submitted on the same claim form. Surgeries that are billed on separate claim forms are denied.

[Certain surgical procedures](#) billed on professional claims (i.e., the 837P (837 Health Care Claim: Professional) transaction or the 1500 Health Care Claim Form) may be reimbursed only when performed in an inpatient hospital or an ASC (ambulatory surgery center).

Reimbursement for most surgical procedures includes reimbursement for preoperative and postoperative care days. Preoperative and postoperative surgical care includes the preoperative evaluation or consultation, postsurgical E&M (evaluation and management) services (i.e., hospital visits, office visits), suture, and cast removal.

Although E&M services pertaining to the surgery for DOS during the preoperative and postoperative care days are not covered, an E&M service may be reimbursed if it was provided in response to a different diagnosis.

Co-surgeons

ForwardHealth reimburses each surgeon at 100 percent of ForwardHealth's usual surgeon rate for the specific procedure he or she has performed. Attach supporting clinical documentation (such as an operative report) clearly marked "co-surgeon" to each surgeon's paper claim to demonstrate medical necessity.

Surgical Assistance

ForwardHealth reimburses surgical assistance services at 20 percent of the reimbursement rate allowed for the provider type for the surgical procedure. To receive reimbursement for surgical assistance, indicate the surgery procedure code with the appropriate assistant surgeon modifier ("80," "81," "82," or "AS") on the claim.

ForwardHealth will automatically calculate the appropriate reimbursement for assistant surgeon services based on the provider type performing the procedure.

Bilateral Surgeries

Bilateral surgical procedures are paid at 150 percent of the maximum allowable fee for the single service. Indicate modifier "50" (bilateral procedure) and a quantity of 1.0 on the claim.

Multiple Surgeries

Multiple surgical procedures performed by the same physician for the same member during the same surgical session are reimbursed at 100 percent of the maximum allowable fee for the primary procedure, 50 percent for the secondary procedure, 25 percent for the tertiary procedure, and 13 percent for all subsequent procedures. The Medicaid-allowed surgery with the greatest usual and customary charge on the claim is reimbursed as the primary surgical procedure, the next highest is the secondary surgical procedure, etc.

ForwardHealth permits full maximum allowable payments for surgeries that are performed on the same DOS but at *different* surgical sessions. For example, if a provider performs a sterilization on the same DOS as a delivery, the provider may be reimbursed the full maximum allowable fee for both procedures if performed at different times (and if all of the billing requirements were met for the sterilization).

To obtain full reimbursement, submit a claim for all the surgeries performed on the same DOS that are being billed for the member. Then submit an [Adjustment/Reconsideration Request \(F-13046 \(07/12\)\)](#) for the allowed claim with additional supporting documentation clarifying that the surgeries were performed in separate surgical sessions.

Note: Most diagnostic and certain vascular injection and radiological procedures are not subject to the multiple surgery reimbursement limits. Call [Provider Services](#) for more information about whether a specific procedure code is subject to these reimbursement limits.

Multiple Births

Reimbursement for multiple births is dependent on the circumstances of the deliveries. If all deliveries are vaginal or if all are Cesarean, the first delivery is reimbursed at 100 percent of ForwardHealth's maximum allowable fee for the service. The second delivery is reimbursed at 50 percent, the third at 25 percent, and subsequent deliveries at 13 percent each.

In the event of a combination of vaginal and Cesarean deliveries, the delivery with the largest billed amount is reimbursed at 100 percent, the delivery with the next largest at 50 percent, and so on, consistent with the policy for other situations of multiple surgeries.

For example, if the initial delivery of triplets is vaginal and the subsequent two deliveries are Cesarean, the first Cesarean delivery is reimbursed at 100 percent, the second Cesarean delivery at 50 percent, and the vaginal delivery at 25 percent.

Preoperative and Postoperative Care

Reimbursement for certain surgical procedures includes the preoperative and postoperative care days associated with that procedure. Preoperative and postoperative surgical care includes the preoperative evaluation or consultation, postsurgical E&M services (i.e., hospital visits, office visits), suture, and cast removal.

Note: Separate reimbursement is allowed for postoperative management when it is performed by a provider other than the surgeon or shared with the surgeon following cataract surgery.

All primary surgeons, surgical assistants, and co-surgeons are subject to the same preoperative and postoperative care limitations for each procedure. For surgical services in which a preoperative period applies, the preoperative period is typically three days. Claims for services which fall within the range of established pre-care and post-care days for the procedure(s) being performed are denied unless they indicate a circumstance or diagnosis code unrelated to the surgical procedure.

For the number of preoperative and postoperative care days applied to a specific procedure code, call Provider Services.

Collecting Payment From Members

Topic #9277

Basic Plan Service Limitations

Services that exceed a service limitation established under the BadgerCare Plus Basic Plan are considered noncovered. Providers are required to follow certain procedures for billing members who receive these services.

Services with Visit Limitations per Enrollment Year

Under the Basic Plan, certain services (e.g., outpatient hospital visits) are covered until a member reaches a specified number of visits or days of service per enrollment year. Visits that exceed the service limitations established under the Basic Plan are considered noncovered. Services provided during a noncovered visit will not be reimbursed by the Basic Plan. Providers are encouraged to inform the member when he or she has reached a service limitation. If a member requests a service that exceeds the limitation, the member is responsible for payment. Providers are strongly encouraged to make payment arrangements with the member in advance.

Services with Dollar Amount Limits per Enrollment Year

Under the Basic Plan, certain services (i.e., DME (durable medical equipment)) are subject to a specified dollar amount service limitation per member per enrollment year. Any products or services that exceed the dollar amount limit are considered noncovered. Providers will be reimbursed for DME provided to Basic Plan members at the lesser of the provider's usual and customary charge or the established maximum allowable fee until the member reaches his or her service limitation of \$500.00 per year.

If BadgerCare Plus covers any portion of the DME charges, providers are required to accept the BadgerCare Plus-allowed reimbursement, which is the lesser of the provider's usual and customary charge or the maximum allowable fee, as payment in full. If BadgerCare Plus pays a portion of the claim and the claim exceeds the member's service limitation, providers can balance bill the member for the difference between the allowed reimbursement and the dollar amount actually paid by BadgerCare Plus.

For example, suppose the BadgerCare Plus-allowed reimbursement for a DME item is \$150.00 and the member has expended \$400.00 of his or her DME coverage for the enrollment year. BadgerCare Plus will reimburse only \$100.00 before the member has exhausted his or her coverage. The member is responsible for the additional \$50.00. The provider must still accept \$150.00 as payment in full because BadgerCare Plus reimbursed a portion of the charges. The provider must not bill the member for more than \$50.00.

If a member has already met or exceeded his or her DME service limitation, BadgerCare Plus will not reimburse providers for DME provided to that member. The provider may collect his or her usual and customary charge from the member.

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.
- Commercial insurance payments made to the member.
- [Spendedown](#).
- Charges for a [private room](#) in a nursing home or hospital.
- Noncovered services if certain conditions are met.
- Covered services for which PA (prior authorization) was denied (or an originally requested service for which a PA request was modified) if certain conditions are met. These services are treated as noncovered services.
- Services provided to a member in a limited benefit category when the services are not covered under the limited benefit and if certain conditions are met.

If a provider inappropriately collects payment from a member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid enrollment.

Copayment

Topic #555

Amounts

BadgerCare Plus Standard Plan, BadgerCare Plus Core Plan, and Medicaid

Copayment amounts for most physician services are determined per procedure code under the BadgerCare Plus Standard Plan, the BadgerCare Plus Core Plan, and Wisconsin Medicaid. They are either based on the maximum allowable fee or are a fixed amount as indicated in the following chart. Providers should use the following chart to determine copayment. Under the Core Plan, there is no copayment for emergency services, anesthesia, or clozapine management.

Copayment amounts for the laboratory and radiology service areas are a fixed amount. Refer to the [laboratory](#) and [radiology](#) service areas for copayment amounts.

Copayment Amounts		
E&M (evaluation and management) services (each office visit, hospital admission, or consultation), based on the maximum allowable fee	Up to \$10.00	\$0.50
	From \$10.01 to \$25.00	\$1.00
	From \$25.01 to \$50.00	\$2.00
	Over \$50.00	\$3.00
Surgery services	Each	\$3.00
Diagnostic services	Each	\$2.00
Allergy testing	Per DOS (date of service)	\$2.00

BadgerCare Plus Benchmark Plan

Copayment for medical services provided under the BadgerCare Plus Benchmark Plan is \$15.00 per visit regardless of the number of services provided during that visit. There are no annual limits to copayments under the Benchmark Plan.

Copayments apply to the following:

- ESRD (end-stage renal disease) services (CPT (Current Procedural Terminology) procedure codes 90951-90970).
- E&M visits (except preventive visits), such as consultations and hospital, outpatient, clinic, nursing home, and home visits.
- Ambulatory surgery facility fees.
- Ophthalmologic exams and refractions.
- Osteopathic manipulations.
- Physical medicine.
- Surgeries.

BadgerCare Plus Basic Plan

The copayment for physician office visits covered under the BadgerCare Plus Basic Plan is \$10.00 per visit. Under the Basic Plan, a provider has the right to deny services if the member fails to make his or her copayment.

Vaccines, including the flu shot (influenza vaccine), have a \$10 copayment.

Note: There is no copayment for SBIRT (Screening, Brief Intervention, and Referral to Treatment) and laboratory services.

Topic #4343

Benchmark Plan Exemptions

Certain BadgerCare Plus Benchmark Plan members are exempt from copayment requirements, including the following:

- Members under 18 years old who are members of a federally recognized tribe.
- Pregnant women.

The following services do not require copayment under the Benchmark Plan:

- Anesthesia services.
- All maternity-related services, including antepartum, delivery, and postpartum care.
- Emergency services.
- Family planning services.
- Immunizations (CPT (Current Procedural Terminology) procedure codes 90281-90749.)
- Lab handling fees and supplies (CPT procedure codes 99000-99002 and 99070).
- Lab, X-ray, and diagnostic tests.
- Miscellaneous services (CPT procedure codes 99170, 99173, 99183-99199).
- Preventive visits (CPT procedure codes 99381-99397).
- Provider-administered drugs.

Topic #231

Exemptions

Wisconsin Medicaid Exemptions

According to [DHS 104.01\(12\)](#), Wis. Admin. Code, providers are prohibited from collecting copayment from the following Wisconsin Medicaid members:

- Children in a mandatory coverage category. In Wisconsin, this includes:
 - Children in foster care, regardless of age.
 - Children in subsidized adoption, regardless of age.
 - Children in the Katie Beckett program, regardless of age.
 - Children under age one with income up to 150 percent of the FPL (Federal Poverty Level).
 - Children ages 1 through 5 with income up to 185 percent of the FPL.
 - Children ages 6 through 18 years of age with incomes at or below 100 percent of the FPL.
- Children who are American Indian or Alaska Natives who are enrolled in the state's CHIP (Child Health Insurance Program).
- American Indians or Alaskan Natives, regardless of age or income level, when they receive items and services either directly from an Indian health care provider or through referral under contract health services.
- Terminally ill individuals receiving hospice care.
- Nursing home residents.

The following services do not require copayment:

- Case management services.
- Crisis intervention services.
- CSP (Community Support Program) services.
- Emergency services.
- Family planning services, including sterilizations.
- HealthCheck "Other Services"
- Home care services.
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- PDN (private duty nursing) and PDN services for ventilator-dependent members.
- SBS (school-based services).
- Substance abuse day treatment services.
- Surgical assistance.

BadgerCare Plus Standard Plan Exemptions

Providers are prohibited from collecting copayment from the following BadgerCare Plus Standard Plan members:

- Children in a mandatory coverage category. In Wisconsin, this includes:
 - Children in foster care, regardless of age.
 - Children in subsidized adoption, regardless of age.
 - Children in the Katie Beckett program, regardless of age.
 - Children under age one with income up to 150 percent of the FPL (Federal Poverty Level).
 - Children ages 1 through 5 with income up to 185 percent of the FPL.
 - Children ages 6 through 18 years of age with incomes at or below 100 percent of the FPL.
- Children who are American Indian or Alaska Natives who are enrolled in the state's CHIP (Child Health Insurance Program).
- American Indians or Alaskan Natives, regardless of age or income level, when they receive items and services either directly from an Indian health care provider or through referral under contract health services.
- Terminally ill individuals receiving hospice care.
- Nursing home residents.

The following services do not require copayment:

- Case management services.
- Crisis intervention services.
- CSP services.
- Emergency services.
- Family planning services, including sterilizations.
- HealthCheck "Other Services."
- Home care services.
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- PDN and PDN services for ventilator-dependent members.
- SBS.
- Substance abuse day treatment services.
- Surgical assistance.

Wisconsin Well Woman Medicaid Exemptions

Providers are prohibited from collecting copayment from members who have been enrolled into WWWMA (Wisconsin Well Woman Medicaid) from the BadgerCare Plus Benchmark Plan or the BadgerCare Plus Core Plan for any Medicaid covered service.

Topic #233

Limitations

Providers should verify that they are collecting the correct copayment for services as some services have monthly or annual copayment limits. Providers may not collect member copayments in amounts that exceed copayment limits.

Resetting Copayment Limitations

Copayment amounts paid by a member enrolled in the BadgerCare Plus Benchmark Plan and the BadgerCare Plus Core Plan within their continuous 12-month enrollment year will reset in the following situations:

- A fee-for-service member is enrolled in an HMO (health maintenance organization).
- A member switches from one HMO to another HMO (only allowable within the first 90 days of Core Plan enrollment).
- A member is disenrolled from an HMO and moves to fee-for-service.

Note: When a member goes from fee-for-service into an HMO and subsequently moves back to fee-for-service, copayments will not be reset for the services that were received under the initial fee-for-service enrollment period.

Resetting copayment limitations does not change a member's [Benchmark Plan](#) enrollment year or a member's [Core Plan](#) enrollment year.

Topic #556

Copayment Limit for Physician Services

A member's copayment for physician services is limited to \$30.00 cumulative, per physician or clinic (using a group billing number), per calendar year under Medicaid and the BadgerCare Plus Standard Plan. A member's copayment for physician services is limited to \$30.00 cumulative, per physician or clinic (using a group billing number), per enrollment year under the BadgerCare Plus Core Plan.

This does not apply to BadgerCare Plus Benchmark Plan members as there are no annual limits to copayments under the Benchmark Plan.

Topic #237

Refund/Collection

If a provider collects a copayment before providing a service and BadgerCare Plus does not reimburse the provider for any part of the service, the provider is required to return or credit the entire copayment amount to the member.

If BadgerCare Plus deducts less copayment than the member paid, the provider is required to return or credit the remainder to the member. If BadgerCare Plus deducts more copayment than the member paid, the provider may collect the remaining amount from the member.

Topic #239

Requirements

Federal law permits states to charge members a copayment for certain covered services. Providers are required to request copayments from members. Providers may not deny services to a Wisconsin Medicaid or BadgerCare Plus Standard Plan member who fails to make a copayment; however, providers may deny services to a BadgerCare Plus Benchmark Plan member, BadgerCare Plus Core Plan member, or BadgerCare Plus Basic Plan member who fails to make a copayment.

Section [49.45\(18\)](#), Wis. Stats., requires providers to make a reasonable attempt to collect copayment from the member unless the provider determines that the cost of collecting the copayment exceeds the amount to be collected.

Payer of Last Resort

Topic #242

Instances When Medicaid Is Not Payer of Last Resort

Wisconsin Medicaid or BadgerCare Plus are *not* the payer of last resort for members who receive coverage from certain governmental programs, such as:

- Birth to 3.
- Crime Victim Compensation Fund.
- GA (General Assistance).
- HCBS (Home and Community-Based Services) waiver programs.
- IDEA (Individuals with Disabilities Education Act).
- Indian Health Service.
- Maternal and Child Health Services.
- WCDP (Wisconsin Chronic Disease Program).
 - Adult Cystic Fibrosis.
 - Chronic Renal Disease.
 - Hemophilia Home Care.

Providers should ask members if they have coverage from these other governmental programs.

If the member becomes retroactively enrolled in Wisconsin Medicaid or BadgerCare Plus, providers who have already been reimbursed by one of these government programs may be required to submit the claims to ForwardHealth and refund the payment from the government program.

Topic #251

Other Health Insurance Sources

BadgerCare Plus reimburses only that portion of the allowed cost remaining after a member's other health insurance sources have been exhausted. Other health insurance sources include the following:

- [Commercial fee-for-service plans](#).
- [Commercial managed care plans](#).
- Medicare supplements (e.g., Medigap).
- Medicare.
- Medicare Advantage.
- TriCare.
- CHAMPVA (Civilian Health and Medical Plan of the Veterans Administration).
- Other governmental benefits.

Topic #253

Payer of Last Resort

Except for a few instances, Wisconsin Medicaid or BadgerCare Plus are the payer of last resort for any covered services. Therefore, the provider is required to make a reasonable effort to exhaust all existing other health insurance sources before submitting claims to ForwardHealth or to a state-contracted MCO (managed care organization).

Topic #255

Primary and Secondary Payers

The terms "primary payer" and "secondary payer" indicate the relative order in which insurance sources are responsible for paying claims.

In general, commercial health insurance is primary to Medicare, and Medicare is primary to Wisconsin Medicaid and BadgerCare Plus. Therefore, Wisconsin Medicaid and BadgerCare Plus are secondary to Medicare, and Medicare is secondary to commercial health insurance.

Reimbursement Not Available

Topic #693

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.

Physician Services Providers

Physician services providers may not receive Medicaid reimbursement for services mentioned in [DHS 107.06\(5\)](#), Wis. Admin. Code.

Nurse Practitioners

Services that nurse practitioners may not receive Medicaid reimbursement for include, but are not limited to, the following:

- Delegated medical acts for which the nurse practitioner does not have written protocols or written or verbal orders.
- Dispensing DME (durable medical equipment).
- Mental health and substance abuse services. (Refer to the [Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults service area](#) for information regarding enrollment and covered services for these services.)
- Services provided to nursing home residents or hospital inpatients when they are included in the calculation of the daily rates for a nursing home or hospital.

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 transfer 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

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Archive Date:01/02/2014

Resources:Contact Information

Topic #476

Member Services

Providers should refer ForwardHealth members with questions to [Member Services](#). The telephone number for Member Services is for member use only.

Topic #473

Provider Relations Representatives

The Provider Relations representatives, also known as field representatives, conduct training sessions on various ForwardHealth topics for both large and small groups of providers and billers. In addition to provider education, field representatives are available to assist providers with complex billing and claims processing questions. Field representatives are located throughout the state to offer detailed assistance to all ForwardHealth providers and all ForwardHealth programs.

Field Representative Specialization

The field representatives are assigned to [specific regions](#) of the state. In addition, the field representatives have [specialized](#) in a group of provider types. This specialization allows the field representatives to most efficiently and effectively address provider inquiries. To better direct inquiries, providers should contact the field representative in [their region who specializes in their provider type](#).

Provider Education

The field representatives' primary focus is provider education. They provide information on ForwardHealth programs and topics in the following ways:

- Conducting provider training sessions throughout the state.
- Providing training and information for newly enrolled providers and/or new staff.
- Participating in professional association meetings.

Providers may also contact the field representatives if there is a specific topic, or topics, on which they would like to have an individualized training session. This could include topics such as use of the Portal (information about claims, enrollment verification, and PA (prior authorization) requests on the Portal). Refer to the [Providers Trainings page](#) for the latest information on training opportunities.

Additional Inquiries

Providers are encouraged to initially obtain information through the ForwardHealth Portal, WiCall, and Provider Services. If these attempts are not successful, field representatives may be contacted for the following types of inquiries:

- Claims, including discrepancies regarding enrollment verification and claim processing.
- PES (Provider Electronic Solutions) claims submission software.
- Claims processing problems that have not been resolved through other channels (e.g., telephone or written

correspondence).

- Referrals by a Provider Services telephone correspondent.
- Complex issues that require extensive explanation.

Field representatives primarily work outside their offices to provide on-site service; therefore, providers should be prepared to leave a complete message when contacting field representatives, including all pertinent information related to the inquiry. Member inquiries should not be directed to field representatives. Providers should refer members to [Member Services](#).

If contacting a field representative by e-mail, providers should ensure that no individually identifiable health information, known as PHI (protected health information), is included in the message. PHI can include things such as the member's name combined with his/her identification number or SSN (Social Security number).

Information to Have Ready

Providers or their representatives should have the following information ready when they call:

- Name or alternate contact.
- County and city where services are provided.
- Name of facility or provider whom they are representing.
- NPI (National Provider Identifier) or provider number.
- Telephone number, including area code.
- A concise statement outlining concern.
- Days and times when available.

For questions about a specific claim, providers should also include the following information:

- Member's name.
- Member identification number.
- Claim number.
- DOS (date of service).

Topic #474

Provider Services

Providers should call [Provider Services](#) to answer enrollment, policy, and billing questions. Members should call [Member Services](#) for information. Members should *not* be referred to Provider Services.

The Provider Services Call Center provides service-specific assistance to Medicaid, BadgerCare Plus, WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program) providers.

Ways Provider Services Can Help

The Provider Services Call Center is organized to include program-specific and service-specific assistance to providers. The Provider Services call center supplements the ForwardHealth Portal and WiCall by providing information on the following:

- Billing and claim submissions.
- Provider enrollment.
- COB (coordination of benefits) (e.g., verifying a member's other health insurance coverage).
- Assistance with completing forms.
- Assistance with remittance information and claim denials.
- Policy clarification.

- PA (prior authorization) status.
- Verifying covered services.

Information to Have Ready

When contacting or transferring from WiCall to the call center, callers will be prompted to enter their NPI (National Provider Identifier) or provider ID. Additionally, to facilitate service, providers are recommended to have all pertinent information related to their inquiry on hand when contacting the call center, including:

- Provider name and NPI or provider ID.
- Member name and member identification number.
- Claim number.
- PA number.
- DOS (dates of service).
- Amount billed.
- RA (Remittance Advice).
- Procedure code of the service in question.
- Reference to any provider publications that address the inquiry.

Call Center Correspondent Team

The ForwardHealth call center correspondents are organized to respond to telephone calls from providers. Correspondents offer assistance and answer inquiries specific to the program (i.e., Medicaid, WCDP, or WWWP) or to the service area (i.e., pharmacy services, hospital services) in which they are designated.

Call Center Menu Options and Inquiries

Providers contacting Provider Services are prompted to select from the following menu options:

- 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 Records) — for EHR inquiries.

Walk-in Appointments

Walk-in appointments offer face-to-face assistance for providers at the Provider Services office. Providers are encouraged to contact the Provider Services Call Center to schedule a walk-in appointment.

Written Inquiries

Providers may contact Provider Services through the Portal by selecting the "Contact Us" link. Provider Services will respond to the inquiry by the preferred method of response indicated within five business days. All information is transmitted via a secure connection to protect personal health information.

Providers may submit written inquiries to ForwardHealth by mail using the [Written Correspondence Inquiry \(F-01170 \(07/12\)\)](#) form. The Written Correspondence Inquiry form may be photocopied or downloaded via a link from the Portal. Written correspondence should be sent to the following address:

ForwardHealth
Provider Services Written Correspondence
313 Blettner Blvd
Madison WI 53784

Providers are encouraged to use the other resources before mailing a written request to ForwardHealth. Provider Services will respond to written inquiries in writing unless otherwise specified.

Topic #475

Provider Suggestions

The DHCAA (Division of Health Care Access and Accountability) is interested in improving its program for providers and members. Providers who would like to suggest a revision of any policy or procedure stated in provider publications or who wish to suggest new policies are encouraged to submit recommendations on the [Provider Suggestion \(F-1016 \(02/09\)\)](#) form.

Topic #4456

Resources Reference Guide

The [Provider Services and Resources Reference Guide](#) lists services and resources available to providers and members with contact information and hours of availability.

Provider Services and Resources 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Electronic transactions. • Companion documents. • Provider Electronic Solutions (PES) software. 		
Managed Care Ombudsman Program	(800) 760-0001	Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central 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 e-mail to trading partners.

Trading partners are encouraged to periodically check for revised companion guides and payer sheet on the Portal. If trading partners do not follow the revisions identified in the companion guides or payer sheet, transactions may not process successfully (e.g., claims may deny or process incorrectly).

A change summary located at the end of the revised companion guide lists the changes that have been made. The date on the companion guide reflects the date the revised companion guide was posted to the Portal. In addition, the version number located in the footer of the first page is changed with each revision.

Revisions to the payer sheet are listed in Appendix A. The date on the payer sheet reflects the date the revised payer sheet was posted to the Portal.

Topic #460

Data Exchange Methods

The following data exchange methods are supported by the [EDI \(Electronic Data Interchange\) Helpdesk](#):

- Remote access server dial-up, using a personal computer with a modem, browser, and encryption software.
- Secure Web, using an Internet Service Provider and a personal computer with a modem, browser, and encryption software.
- Real-time, by which trading partners exchange the NCPDP (National Council for Prescription Drug Programs) D.0, 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response), 276/277 (276/277 Health Care Claim Status Request and Response), or 278 (278 Health Care Services Review — Request for Review and Response) transactions via an approved clearinghouse.

The EDI Helpdesk supports the exchange of the transactions for BadgerCare Plus, Medicaid, SeniorCare, 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 Health Care Eligibility/Benefit Inquiry and Information Response). The 270 is the electronic transaction

for inquiring about a member's enrollment. The 271 is received in response to the inquiry.

- 276/277 (276/277 Health Care Claim Status Request and Response). The 276 is the electronic transaction for checking claim status. The 277 is received in response.
- 278 (278 Health Care Services Review - Request for Review and Response). The electronic transaction for health care service PA (prior authorization) requests.
- 835 (835 Health Care Claim Payment/Advice). The electronic transaction for receiving remittance information.
- 837 (837 Health Care Claim). The electronic transaction for submitting claims and adjustment requests.
- 999 (999 Functional Acknowledgment). The electronic transaction for reporting whether a transaction is accepted or rejected.
- TA1 InterChange Acknowledgment. The electronic transaction for reporting a transaction that is rejected for interChange-level errors.
- NCPDP D.0 Telecommunication Standard for Retail Pharmacy Claims. The real-time POS (Point-of-Sale) electronic transaction for submitting pharmacy claims.

Topic #463

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. PES (Provider Electronic Solutions) software allows providers to submit 837 (837 Health Care Claim) transactions and download the 999 (999 Functional Acknowledgment) and the 835 (835 Health Care Claim Payment/Advice) transactions. To obtain PES software, providers may download it from the [ForwardHealth Portal](#). For assistance installing and using PES software, providers may call the [EDI \(Electronic Data Interchange\) Helpdesk](#).

Topic #464

Trading Partner Profile

A [Trading Partner Profile](#) must be completed and signed for each billing provider number that will be used to exchange electronic transactions.

In addition, billing providers who do not use a third party to exchange electronic transactions, billing services, and clearinghouses are required to complete a Trading Partner Profile.

To determine whether a Trading Partner Profile is required, providers should refer to the following:

- Billing providers who do not use a third party to exchange electronic transactions, including providers who use the PES (Provider Electronic Solutions) software, are required to complete the Trading Partner Profile.
- Billing providers who use a third party (billing services and clearinghouses) to exchange electronic transactions are required to submit a Trading Partner Profile.
- Billing services and clearinghouses, including those that use PES software, that are authorized by providers to exchange electronic transactions on a provider's behalf, are required to submit a Trading Partner Profile.

Providers who change billing services and clearinghouses or become a trading partner should keep their information updated by contacting the [EDI \(Electronic Data Interchange\) Helpdesk](#).

Topic #465

Trading Partners

ForwardHealth exchanges nationally recognized electronic transactions with trading partners. A "trading partner" is defined as a covered entity that exchanges electronic health care transactions. The following covered entities are considered trading partners:

- Providers who exchange electronic transactions directly with ForwardHealth.
- Billing services and clearinghouses that exchange electronic transactions directly with ForwardHealth on behalf of a billing provider.

Enrollment Verification

Topic #256

270/271 Transactions

The [270/271 \(270/271 Health Care Eligibility/Benefit Inquiry and Information Response\)](#) transactions allow for batch enrollment verification, including information for the current benefit month or for any date of eligibility the member has on file, through a secure Internet connection. The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.

For those providers who are federally required to have an NPI (National Provider Identifier), an NPI is required on the 270/271 transactions. The NPI indicated on the 270 is verified to ensure it is associated with a valid enrollment on file with ForwardHealth. The 271 response will report the NPI that was indicated on the 270.

For those providers exempt from NPI, a provider ID is required on the 270/271 transactions. The provider ID indicated on the 270 is verified to ensure it is associated with a valid enrollment on file with ForwardHealth. The 271 response will report the provider ID that was indicated on the 270.

Topic #469

An Overview

Providers should always verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Each enrollment verification method allows providers to verify the following prior to services being rendered:

- A member's enrollment in a ForwardHealth program(s).
- State-contracted MCO (managed care organization) enrollment.
- Medicare enrollment.
- Limited benefits categories.
- Any other commercial health insurance coverage.
- Exemption from copayments for BadgerCare Plus members.

Topic #259

Commercial Enrollment Verification Vendors

ForwardHealth has agreements with several [commercial enrollment verification vendors](#) to offer enrollment verification technology to ForwardHealth providers. Commercial enrollment verification vendors have up-to-date access to the ForwardHealth enrollment files to ensure that providers have access to the most current enrollment information. Providers may access Wisconsin's EVS (Enrollment Verification System) to verify member enrollment through one or more of the following methods available from commercial enrollment verification vendors:

- Magnetic stripe card readers.
- Personal computer software.
- Internet.

Vendors sell magnetic stripe card readers, personal computer software, Internet access, and other services. They also provide ongoing maintenance, operations, and upgrades of their systems. Providers are responsible for the costs of using these enrollment verification methods.

Note: Providers are *not* required to purchase services from a commercial enrollment verification vendor. For more information on other ways to verify member enrollment or for questions about ForwardHealth identification cards, contact [Provider Services](#).

The real-time enrollment verification methods allow providers to print a paper copy of the member's enrollment information, including a transaction number, for their records. Providers should retain this number or the printout as proof that an inquiry was made.

Magnetic Stripe Card Readers

The magnetic stripe card readers resemble credit card readers. Some ForwardHealth identification cards have a magnetic stripe and signature panel on the back, and a unique, 16-digit card number on the front. The 16-digit card number is valid only for use with a magnetic card reader.

Providers receive current member enrollment information after passing the ForwardHealth card through the reader or entering the member identification number or card number into a keypad and entering the DOS (date of service) about which they are inquiring.

Personal Computer Software

Personal computer software can be integrated into a provider's current computer system by using a modem and can access the same information as the magnetic stripe card readers.

Internet Access

Some enrollment verification vendors provide real-time access to enrollment from the EVS through the Internet.

Topic #4903

Copayment Information

If a member is enrolled in BadgerCare Plus or Wisconsin Medicaid and is exempt from paying copayments for services, providers will receive the following response to an enrollment query from all methods of enrollment verification:

- The name of the benefit plan.
- The member's enrollment dates.
- The message, "No Copay."

If a member is enrolled in BadgerCare Plus, Medicaid, or SeniorCare and is required to pay a copayment, the provider will be given the name of the benefit plan in which the member is enrolled and the member's enrollment dates for the benefit plan only.

Note: The BadgerCare Plus Core Plan may also charge different copayments for hospital services depending on the member's income level. Members identified as "BadgerCare Plus Core Plan 1" are subject to lower copayments for hospital services. Members identified as "BadgerCare Plus Core Plan 2" are subject to higher copayments for hospital services.

Topic #264

Enrollment Verification System

Member enrollment issues are the primary reason claims are denied. To reduce claim denials, providers should *always* verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Providers may want to verify the member's enrollment a second time before submitting a claim to find out whether the member's enrollment information has changed since the appointment.

Providers can access Wisconsin's EVS (Enrollment Verification System) to receive the most current enrollment information through the following methods:

- ForwardHealth Portal.
- [WiCall](#), Wisconsin's AVR (Automated Voice Response) system.
- Commercial enrollment verification vendors.
- 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Response) transactions.
- [Provider Services](#).

Providers cannot charge a member, or authorized person acting on behalf of the member, for verifying his or her enrollment.

The EVS does not indicate other government programs that are secondary to Wisconsin Medicaid.

Topic #4901

Enrollment Verification on the Portal

The secure ForwardHealth Portal offers real-time member enrollment verification for all ForwardHealth programs. Providers will be able to use this tool to determine:

- The benefit plan(s) in which the member is enrolled.
- If the member is enrolled in a state-contracted managed care program (for Medicaid and BadgerCare Plus members).
- If the member has any other coverage, such as Medicare or commercial health insurance.
- If the member is exempted from copayments (BadgerCare Plus members only).

To access enrollment verification via the ForwardHealth Portal, providers will need to do the following:

- Go to the ForwardHealth Portal.
- Establish a provider account.
- Log into the secure Portal.
- Click on the menu item for enrollment verification.

Providers will receive a unique transaction number for each enrollment verification inquiry. Providers may access a history of their enrollment inquiries using the Portal, which will list the date the inquiry was made and the enrollment information that was given on the date that the inquiry was made. For a more permanent record of inquiries, providers are advised to use the "print screen" function to save a paper copy of enrollment verification inquiries for their records or document the transaction number at the beginning of the response, for tracking or research purposes. This feature allows providers to access enrollment verification history when researching claim denials due to enrollment issues.

The Provider Portal is available 24 hours a day, seven days a week.

Topic #4900

Entering Dates of Service

Enrollment information is provided based on a "From" DOS (date of service) and a "To" DOS that the provider enters when making the enrollment inquiry. For enrollment inquiries, a "From" DOS is the earliest date for which the provider is requesting enrollment information and the "To" DOS is the latest date for which the provider is requesting enrollment information.

Providers should use the following guidelines for entering DOS when verifying enrollment for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, or WCDP (Wisconsin Chronic Disease Program) members:

- The "From" DOS is the earliest date the provider requires enrollment information.
- The "To" DOS must be within 365 days of the "From" DOS.
- If the date of the request is prior to the 20th of the current month, then providers may enter a "From" DOS and "To" DOS up to the end of the current calendar month.
- If the date of the request is on or after the 20th of the current month, then providers may enter a "From" DOS and "To" DOS up to the end of the following calendar month.

For example, if the date of the request was November 15, 2008, the provider could request dates up to and including November 30, 2008. If the date of the request was November 25, 2008, the provider could request dates up to and including December 31, 2008.

Topic #265

Member Forgets ForwardHealth Identification Card

Even if a member does not present a ForwardHealth identification card, a provider can use Wisconsin's EVS (Enrollment Verification System) to verify enrollment; otherwise, the provider may choose not to provide the service(s) until a member brings in a ForwardHealth card.

A provider may use a combination of the member's name, date of birth, ForwardHealth identification number, or SSN (Social Security number) with a "0" at the end to access enrollment information through the EVS.

A provider may call [Provider Services](#) with the member's full name and date of birth to obtain the member's enrollment information if the member's identification number or SSN is not known.

Topic #4899

Member Identification Card Does Not Guarantee Enrollment

Most members receive a member identification card, but possession of a program identification card does not guarantee enrollment. Periodically, members may become ineligible for enrollment, only to re-enroll at a later date. Members are told to keep their cards even though they may have gaps in enrollment periods. It is possible that a member will present a card when he or she is not enrolled; therefore, it is essential that providers verify enrollment before providing services. To reduce claim denials, it is important that providers verify the following information prior to each DOS (date of service) that services are provided:

- If a member is enrolled in any ForwardHealth program, including benefit plan limitations.
- If a member is enrolled in a managed care organization.
- If a member is in primary provider lock-in status.
- If a member has Medicare or other insurance coverage.

Topic #4898

Responses Are Based on Financial Payer

When making an enrollment inquiry through Wisconsin's EVS (Enrollment Verification System), the returned response will provide information on the member's enrollment in benefit plans based on financial payers.

There are three financial payers under ForwardHealth:

- Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and SeniorCare).
- WCDP (Wisconsin Chronic Disease Program).
- WWWP (Wisconsin Well Woman Program).

Within each financial payer are benefit plans. Each member is enrolled under at least one of the three financial payers, and under each financial payer, is enrolled in at least one benefit plan. An individual member may be enrolled under more than one financial payer. (For instance, a member with chronic renal disease may have health care coverage under the BadgerCare Plus Standard Plan and the WCDP chronic renal disease program. The member is enrolled under two financial payers, Medicaid and WCDP.) Alternatively, a member may have multiple benefits under a single financial payer. (For example, a member may be covered by the TB-Only (Tuberculosis-Related Services Only) Benefit and Family Planning Only Services at the same time, both of which are administered by Medicaid.)

Forms

Topic #767

An Overview

ForwardHealth requires providers to use a variety of forms for PA (prior authorization), claims processing, and documenting special circumstances.

Topic #470

Fillable Forms

Most forms may be obtained from the [Forms](#) page of the ForwardHealth Portal.

Forms on the Portal are available as fillable PDF (Portable Document Format) files, which can be viewed with Adobe Reader[®] computer software. Providers may also complete and print fillable PDF files using Adobe Reader[®].

To complete a fillable PDF, follow these steps:

- Select a specific form.
- Save the form to the computer.
- Use the "Tab" key to move from field to field.

Note: The Portal provides instructions on how to obtain Adobe Reader[®] at no charge from the Adobe[®] Web site. Adobe Reader[®] only allows providers to view and print completed PDFs. It does not allow users to save completed fillable PDFs to their computer; however, if Adobe Acrobat[®] is purchased, providers may save completed PDFs to their computer. Refer to the [Adobe[®] Web site](#) for more information about fillable PDFs.

Selected forms are also available in fillable Microsoft[®] Word format on the Portal. The fillable Microsoft[®] Word format allows providers to complete and print the form using Microsoft[®] Word. To complete a fillable Microsoft[®] Word form, follow these steps:

- Select a specific form.
- Save the form to the computer.
- Use the "Tab" key to move from field to field.

Note: Providers may save fillable Microsoft[®] Word documents to their computer by choosing "Save As" from the "File" menu, creating a file name, and selecting "Save" on their desktop.

Topic #766

Telephone or Mail Requests

Providers who do not have Internet access or who need forms that are not available on the ForwardHealth Portal may obtain them by doing either of the following:

- Requesting a paper copy of the form by calling [Provider Services](#). Questions about forms may also be directed to Provider Services.
- Submitting a written request and mailing it to ForwardHealth. Include a return address, the name of the form, and the form number and send the request to the following address:

ForwardHealth
Form Reorder
313 Blettner Blvd
Madison WI 53784

Portal

Topic #4904

Claims and Adjustments Using the ForwardHealth Portal

Providers can [track the status](#) of their submitted claims, [submit individual claims](#), correct errors on claims, copy claims, and determine what claims are in "pay" status on the ForwardHealth Portal. Providers have the ability to [search for and view](#) the status of all their finalized claims, regardless of how they were submitted (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim through DDE (Direct Data Entry) through the secure Portal.

Topic #8524

Conducting Revalidation Via the ForwardHealth Portal

Providers can conduct [revalidation](#) online via a secure revalidation area of the ForwardHealth Portal.

Topic #5157

Cost Share Reports for Long-Term Managed Care Organizations

Individual cost share reports for long-term care MCOs (managed care organizations) that provide Family Care, Family Care Partnership, and PACE (Program of All-Inclusive Care for the Elderly) services are available via the secure area of the ForwardHealth Portal and can be downloaded as an Excel file.

Topic #4345

Creating a Provider Account

Each provider needs to designate one individual as an administrator of the ForwardHealth Portal account. This user establishes the administrative account once his or her PIN (personal identification number) is received. The administrative user is responsible for this provider account and is able to add accounts for other users (clerks) within his or her organization and assign security roles to clerks that have been established. To establish an administrative account after receiving a PIN, the administrative user is required to follow these steps:

1. Go to the ForwardHealth Portal.
2. Click the **Providers** button.
3. Click **Logging in for the first time?**.
4. Enter the Login ID and PIN. The Login ID is the provider's NPI or provider number.
5. Click **Setup Account**.
6. At the Account Setup screen, enter the user's information in the required fields.

7. Read the security agreement and click the checkbox to indicate agreement with its contents.
8. Click **Submit** when complete.

Once in the secure Provider area of the Portal, the provider may conduct business online with ForwardHealth via a secure connection. Providers may also perform the following administrative functions from the Provider area of the Portal:

- Establish accounts and define access levels for clerks.
- Add other organizations to the account.
- Switch organizations.

Refer to the Account User Guide on the [Portal User Guides page](#) of the Portal for more detailed instructions on performing these functions.

Topic #4340

Designating a Trading Partner to Receive 835 Health Care Claim Payment/Advice Transactions

Providers must designate a trading partner to receive their 835 (835 Health Care Claim Payment/Advice) transaction for ForwardHealth interChange.

Providers who wish to submit their [835](#) designation via the Portal are required to create and establish a provider account to have access to the secure area of the Portal.

To designate a trading partner to receive 835 transactions, providers must first complete the following steps:

- Access the Portal and log into their secure account by clicking the Provider link/button.
- Click on the Designate 835 Receiver link on the right-hand side of the secure home page.
- Enter the identification number of the trading partner that is to receive the 835 in the Trading Partner ID field.
- Click Save.

Providers who are unable to use the Portal to designate a trading partner to receive 835 transactions may call the [EDI \(Electronic Data Interchange\) Helpdesk](#) or submit a [paper \(Trading Partner 835 Designation, F-13393 \(07/12\)\)](#) form.

Topic #5087

Electronic Communications

The secure ForwardHealth Portal contains a one-way message center where providers can receive electronic notifications and provider publications from ForwardHealth. All new messages display on the provider's main page within the secure Portal.

Topic #5088

Enrollment Verification

The secure ForwardHealth Portal offers real time member [enrollment verification](#) for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled.

- Whether or not the member is enrolled in a state-contracted MCO (managed care organization).
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance.
- Whether or not the member is enrolled in the [Pharmacy Services Lock-In Program](#) and the member's Lock-In pharmacy, primary care provider, and referral providers (if applicable).

Using the Portal to check enrollment may be more effective than calling [WiCall](#) or the EVS (Enrollment Verification System) (although both are available).

Providers are assigned a unique enrollment verification number for each inquiry. Providers can also use the "print screen" function to print a paper copy of enrollment verification inquiries for their records.

Topic #4338

ForwardHealth Portal

Providers, members, trading partners, managed care programs, and partners have access to public *and* secure information through the ForwardHealth Portal.

The Portal has the following areas:

- Providers (public and secure).
- Trading Partners.
- Members.
- MCO (managed care organization).
- Partners.

The secure Portal allows providers to conduct business and exchange electronic transactions with ForwardHealth. The public Portal contains general information accessible to all users. Members can access general health care program information and apply for benefits [online](#).

Topic #4441

ForwardHealth Portal Helpdesk

Providers and trading partners may call the [ForwardHealth Portal Helpdesk](#) with technical questions on Portal functions, including their Portal accounts, registrations, passwords, and submissions through the Portal.

Topic #4581

HealthCheck Information Available Through the ForwardHealth Portal

HealthCheck providers can access outreach reports and view screening history, the HealthCheck Periodicity Schedule, and the WIR (Wisconsin Immunization Registry) through the ForwardHealth Portal.

HealthCheck Agency Portal Outreach Reports

HealthCheck Agency Outreach reports are available through the secure area of the Portal for agencies with "active" Portal user IDs. HealthCheck Outreach Agencies receive a notification in their message box when updated monthly and quarterly reports are

available. The message gives providers instructions on how to download their files. Notifications in the message box are retained for seven calendar days.

The monthly report, titled "HealthCheck Monthly Screening," is uploaded every 28 days and the quarterly report, titled "HealthCheck Quarterly Eligibility Member," is replaced every 88 days by a new report with updated information.

Paper reports are still mailed to providers without a Portal account.

HealthCheck Screening Inquiry

Providers may use the online inquiry function to query a member's HealthCheck screening history by entering one of the following:

- Member identification number.
- Member's first and last name and date of birth.
- Member Social Security number and date of birth.

Once the member information is entered, the following member information is displayed:

- Member ID.
- First and last name.
- Date of last HealthCheck screening.
- Date of last preventive dental visit.
- Date of birth.

If the member has additional past HealthCheck screenings or preventative dental visits, the history of the member is displayed in the "Search Results" panel including:

- Previous date(s) of service.
- Name(s) of provider(s) that performed past screening(s) or dental visit(s).
- Member age at time of previous screening(s) or dental visit(s).
- Status of the claim(s).

Information about HealthCheck screenings reimbursed by fee-for-service or HMOs (health maintenance organizations) is available through the HealthCheck screening inquiry.

Note: Providers have 365 days from the date of service to submit a claim and HMOs have one year to submit encounter data. Therefore, delayed submission of HealthCheck screening information affects the availability of data in the screening query.

Periodicity Screening Schedule

A Periodicity Screening Schedule that lists the frequency and timing of recommended HealthCheck screenings is available for providers to review on the Provider Portal.

Wisconsin Immunization Registry

A link on the HealthCheck page in the Portal connects users to the WIR Web site to view immunization data. Wisconsin Immunization Registry will continue to monitor all vaccination information for children, maintain recommended immunization schedules, record immunizations, track contraindications and reactions, and verify immunization history. Additionally, complete blood lead testing history with the testing results are available.

Providers may access the WIR Web site via the Portal or may continue to access the site directly at <https://www.dhfwir.org/>. Login and password requirements for WIR apply regardless of the link used to reach the Web site.

Topic #4451

Inquiries to ForwardHealth Via the Portal

Providers are able to contact Provider Services through the ForwardHealth Portal by clicking the [Contact](#) link and entering the relevant inquiry information, including selecting the preferred method of response (i.e., telephone call or e-mail). Provider Services will respond to the inquiry by the preferred method of response indicated within five business days.

Topic #4400

Internet Connection Speed

ForwardHealth recommends providers have an Internet connection that will provide an upload speed of at least 768 Kbps and a download speed of at least 128 Kbps in order to efficiently conduct business with ForwardHealth via the Portal.

For [PES \(Provider Electronic Solutions\)](#) users, ForwardHealth recommends an Internet connection that will provide a download speed of at least 128 Kbps for downloading PES software and software updates from the Portal.

These download speeds are generally not available through a dial-up connection.

Topic #4351

Logging in to the Provider Area of the Portal

Once an administrative user's or other user's account is set up, he or she may log in to the Provider area of the ForwardHealth Portal to conduct business. To log in, the user is required to click the "Provider" link or button, then enter his or her username and password and click "Go" in the Login to Secure Site box at the right side of the screen.

Topic #4743

Managed Care Organization Portal

Information and Functions Through the Portal

The [MCO \(managed care organization\) area](#) of the ForwardHealth Portal allows state-contracted MCOs to conduct business with ForwardHealth. The Public MCO page offers easy access to key MCO information and Web tools. A log-in is required to access the secure area of the Portal to submit or retrieve account and member information which may be sensitive.

The following information is available through the Portal:

- Listing of all Medicaid-enrolled providers.
- Coordination of Benefits Extract/Insurance Carrier Master List information updated quarterly.
- Data Warehouse, which is linked from the Portal to Business Objects. The Business Objects function allows for access to MCO data for long term care MCOs.
- Electronic messages.
- Enrollment verification by entering a member ID or SSN (Social Security number) with date of birth and a "from DOS (date of service)" and a "to DOS" range. A transaction number is assigned to track the request.
- Member search function for retrieving member information such as medical status code, and managed care and Medicare

information.

- Provider search function for retrieving provider information such as address, telephone number, provider ID, taxonomy code (if applicable), and provider type and specialty.
- HealthCheck information.
- MCO contact information.
- Technical contact information. Entries may be added via the Portal.

Topic #5158

Managed Care Organization Portal Reports

The following reports are generated to MCOs (managed care organizations) through their account on the ForwardHealth MCO Portal:

- Capitation Payment Listing Report.
- Cost Share Report (long-term MCOs only).
- Enrollment Reports.

MCOs are required to establish a Portal account in order to receive reports from ForwardHealth.

Capitation Payment Listing Report

The Capitation Payment Listing Report provides "payee" MCOs with a detailed listing of the members for whom they receive capitation payments. ForwardHealth interChange creates adjustment transaction information weekly and regular capitation transaction information monthly. The weekly batch report includes regular and adjustment capitation transactions. MCOs have the option of receiving both the Capitation Payment Listing Report and the 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transactions.

Initial Enrollment Roster Report

The Initial Enrollment Roster Report is generated according to the annual schedules detailing the number of new and continuing members enrolled in the MCO and those disenrolled before the next enrollment month.

Final Enrollment Roster Report

The Final Enrollment Roster Report is generated the last business day of each month and includes members who have had a change in status since the initial report and new members who were enrolled after the Initial Enrollment Roster Report was generated.

Other Reports

Additional reports are available for BadgerCare Plus HMOs, SSI HMOs, and long-term MCOs. Some are available via the Portal and some in the secure FTP (file transfer protocol).

Topic #4744

Members ForwardHealth Portal

Members can access ForwardHealth information by going to the ForwardHealth Portal. Members can search through a directory

of providers by entering a ZIP code, city, or county. Members can also access all member-related ForwardHealth applications and forms. Members can use [ACCESS](#) to check availability, apply for benefits, check current benefits, and report any changes.

Topic #4344

Obtaining a Personal Identification Number

To establish an account on the ForwardHealth Portal, providers are required to obtain a PIN (personal identification number). The PIN is a unique, nine-digit number assigned by ForwardHealth interChange for the sole purpose of allowing a provider to establish a Portal account. It is used in conjunction with the provider's login ID. Once the Portal account is established, the provider will be prompted to create a username and password for the account, which will subsequently be used to log in to the Portal.

Note: The PIN used to create the provider's Portal account is not the same PIN used for revalidation. Providers will receive a separate PIN for revalidation.

A provider may need to request more than one PIN if he or she is a provider for more than one program or has more than one type of provider enrollment. A separate PIN will be needed for each provider enrollment. Health care providers will need to supply their NPI (National Provider Identifier) and corresponding taxonomy code when requesting an account. Non-healthcare providers will need to supply their unique provider number.

Providers may request a PIN by following these steps:

1. Go to the [Portal](#).
2. Click on the "Providers" link or button.
3. Click the "Request Portal Access" link from the Quick Links box on the right side of the screen.
4. At the Request Portal Access screen, enter the following information:
 - a. Health care providers are required to enter their NPI and click "Search" to display a listing of ForwardHealth enrollments. Select the correct enrollment for the account. The taxonomy code, ZIP+4 code, and financial payer for that enrollment will be automatically populated. Enter the SSN (Social Security number) or TIN (Tax Identification Number).
 - b. Non-healthcare providers are required to enter their provider number, financial payer, and SSN or TIN. (This option should only be used by non-healthcare providers who are exempt from NPI requirements).

The financial payer is one of the following:

- Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and Senior Care).
 - SSI (Supplemental Security Income).
 - WCDP (Wisconsin Chronic Disease Program).
 - The WWWP (Wisconsin Well Woman Program).
- c. Click **Submit**.
 - d. Once the Portal Access Request is successfully completed, ForwardHealth will send a letter with the provider's PIN to the address on file.

Topic #4459

Online Handbook

The Online Handbook allows providers access to all policy and billing information for Wisconsin Medicaid, BadgerCare Plus, ADAP (Wisconsin AIDS Drug Assistance Program), and WCDP (Wisconsin Chronic Disease Program) in one centralized place. A secure ForwardHealth Portal account is not required to use the Online Handbook as it is available to all Portal visitors.

Revisions to policy information are incorporated immediately after policy changes have been issued in *ForwardHealth Updates*. The Online Handbook also links to the [ForwardHealth Publications page](#), an archive section that providers can use to research past policy and procedure information.

The Online Handbook, which is available through the public area of the Portal, is designed to sort information based on user-entered criteria, such as program and provider type. It is organized into sections and chapters. Sections within each handbook may include the following:

- Claims.
- Coordination of Benefits.
- Managed Care.
- Member Information.
- Prior Authorization.
- Provider Enrollment and Ongoing Responsibilities.
- Reimbursement.
- Resources.

Each section consists of separate chapters (e.g., claims submission, procedure codes), which contain further detailed information.

Advanced Search Function

The Online Handbook has an advanced search function, which allows providers to search for a specific word or phrase within a user type, program, service area, or throughout the entire Online Handbook.

Providers can access the advanced search function by following these steps:

1. Go to the Portal.
2. Click the "Online Handbooks" link in the upper left "Providers" box.
3. Complete the two drop-down selections at the right to narrow the search by program and service area, if applicable. This is not needed if providers wish to search the entire Online Handbook.
4. Click "Advanced Search" to open the advanced search options.
5. Enter the word or phrase you would like to search.
6. Select "Search within the options selected above" or "Search all handbooks, programs and service areas."
7. Click the "Search" button.

ForwardHealth Publications Archive Area

The ForwardHealth Publications page of the Online Handbook allows providers to view old *Updates* and previous versions of the Online Handbook.

Providers can access the archive information area by following these steps:

1. Go to the Portal.
2. Click the "Online Handbooks" link in the upper left "Providers" box.
3. Click on the "Updates and Handbooks" link. (This link is below the three drop-down menus.)

Topic #5089

Other Business Enhancements Available on the Portal

The secure Provider area of the ForwardHealth Portal enables providers to do the following:

- Verify member enrollment.
- View RAs (Remittance Advice).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice).
- Update and maintain provider file information. Providers have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT (electronic funds transfer).
- Track provider-submitted PA (prior authorization) requests.

Topic #4911

Portal Account Administrators

Portal administrators are responsible for requesting, creating, and managing accounts to access these features for their organization.

There must be one administrator assigned for each Portal account and all users established for that account. The responsibilities of the Portal administrator include:

- Ensuring the security and integrity of all user accounts (clerk administrators and clerks) created and associated with their Portal account.
- Ensuring clerks or clerk administrators are given the appropriate authorizations they need to perform their functions for the provider, trading partner, or MCO (managed care organization).
- Ensuring that clerks or clerk administrator accounts are removed/deleted promptly when the user leaves the organization.
- Ensuring that the transactions submitted are valid and recognized by ForwardHealth.
- Ensuring that all users they establish know and follow security and guidelines as required by HIPAA (Health Insurance Portability and Accountability Act of 1996). As Portal administrators establish their Portal account and create accounts for others to access private information, administrators are reminded that all users must comply with HIPAA. The HIPAA privacy and security rules require that the confidentiality, integrity, and availability of PHI (protected health information) are maintained at all times. The HIPAA Privacy Rule provides guidelines governing the disclosure of PHI. The HIPAA Security Rule delineates the security measures to be implemented for the protection of electronic PHI. If Portal administrators have any questions concerning the protection of PHI, visit the Portal for additional information.

Portal administrators have access to all secure functions for their Portal account.

Establish an Administrator Account

All Portal accounts require an administrator account. The administrator is a selected individual who has overall responsibility for management of the account. Therefore, he or she has complete access to all functions within the specific secure area of his or her Portal and are permitted to add, remove, and manage other individual roles.

Topic #4912

Portal Clerk Administrators

A Portal administrator may choose to delegate some of the authority and responsibility for setting up and managing the users within their ForwardHealth Portal account. If so, the Portal administrator may establish a clerk administrator. An administrator or clerk administrator can create, modify, manage or remove clerks for a Portal account. When a clerk is created, the administrator or clerk administrator must grant permissions to the clerks to ensure they have the appropriate access to the functions they will

perform. A clerk administrator can only grant permissions that they themselves have. For example, if an administrator gives a clerk administrator permission only for enrollment verification, then the clerk administrator can only establish clerks with enrollment verification permissions.

Even if a Portal administrator chooses to create a clerk administrator and delegate the ability to add, modify, and remove users from the same account, the Portal administrator is still responsible for ensuring the integrity and security of the Portal account.

Topic #4913

Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their ForwardHealth Portal account. Clerks may be assigned one or many roles (i.e., claims, PA (prior authorization), member enrollment verification). Clerks do not have the ability to establish, modify, or remove other accounts.

Once a clerk account is set up, the clerk account does not have to be established again for a separate Portal account. Clerks can easily be assigned a role for different Portal accounts (i.e., different ForwardHealth enrollments). To perform work under a different Portal account for which they have been granted authorization, a clerk can use the "switch org" function and toggle between the Portal accounts to which they have access. Clerks may be granted different authorization in each Portal account (i.e., they may do member enrollment verification for one Portal account, and HealthCheck inquires for another).

Topic #4740

Public Area of the Provider Portal

The public Provider area of the ForwardHealth Portal offers a variety of important business features and functions that will greatly assist in daily business activities with ForwardHealth programs.

Maximum Allowable Fee Schedules

Within the Portal, all [maximum allowable fee schedules](#) for Medicaid, BadgerCare Plus, and WCDP (Wisconsin Chronic Disease Program) are interactive and searchable. Providers can enter the DOS (date of service), along with other information such as procedure code, category of supplies, or provider type, to find the maximum allowable fee. Providers can also download all fee schedules.

Online Handbook

The Online Handbook is the single source for all current policy and billing information for ForwardHealth. The Online Handbook is designed to sort information based on user-entered criteria, such as program and provider type.

Revisions to policy information are incorporated into the Online Handbook in conjunction with published *Updates*. The Online Handbook also links to the [ForwardHealth Publications page](#), an archive section where providers can research previously published *Updates*.

ForwardHealth Publications Archive Section

The [ForwardHealth Publications page](#), available via the Quick Links box, lists *Updates*, *Update Summaries*, archives of provider Handbooks and provider guides, and monthly archives of the Online Handbook. The ForwardHealth Publications page contains both current and obsolete information for research purposes only. Providers should use the Online Handbook for current policy and procedure questions. The *Updates* are searchable by provider type or program (e.g., physician or HealthCheck

"Other Services") and by year of publication.

Training

Providers can register for all scheduled trainings and view online trainings via the [Portal Training page](#), which contains an up-to-date calendar of all available training. Additionally, providers can view [Webcasts](#) of select trainings.

Contacting Provider Services

Providers and other Portal users will have an additional option for contacting Provider Services through the Contact link on the Portal. Providers can enter the relevant inquiry information, including selecting the preferred method of response (i.e., telephone call or e-mail) the provider wishes to receive back from Provider Services. Provider Services will respond to the inquiry within five business days. Information will be submitted via a secure connection.

Online Enrollment

Providers can speed up the enrollment process for Medicaid by completing a [provider enrollment application](#) via the Portal. Providers can then track their application by entering their ATN (application tracking number) given to them on completion of the application.

Other Business Enhancements Available on the Portal

The public Provider area of the Portal also includes the following features:

- A ["What's New?"](#) section for providers that links to the latest provider publication summaries and other new information posted to the Provider area of the Portal.
- Home page for the provider. Providers have administrative control over their Portal homepage and can grant other employees access to specified areas of the Portal, such as claims and PA (prior authorization).
- [E-mail subscription](#) service for *Updates*. Providers can register for e-mail subscription to receive notifications of new provider publications via e-mail. Users are able to select, by program and service area, which publication notifications they would like to receive.
- A [forms library](#).

Topic #4741

Secure Area of the Provider Portal

Providers can accomplish many processes via the ForwardHealth Portal, including submitting, adjusting, and correcting claims, submitting and amending PA (prior authorization) requests, and verifying enrollment.

Claims and Adjustments Using the Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, and determine what claims are in "pay" status on the Portal. Providers have the ability to search for and view the status of all of their finalized claims, regardless of how they were submitted (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim via DDE (Direct Data Entry) through the secure Portal.

Submitting Prior Authorization and Amendment Requests Via the Portal

Nearly all service areas can submit PA requests via the Portal. Providers can do the following:

- Correct errors on PA or amendment requests via the Portal, regardless of how the PA request was originally submitted.
- View all recently submitted and finalized PA and amendment requests.
- Save a partially completed PA request and finish completing it at a later time. (*Note:* Providers are required to submit or re-save a PA request within 30 calendar days of the date the PA request was last saved.)
- View all saved PA requests and select any to continue completing or delete.
- View the latest provider review and decision letters.
- Receive messages about PA and amendment requests that have been adjudicated or returned for provider review.

Electronic Communications

The secure Portal contains a one-way message center where providers can receive electronic notifications and provider publications from ForwardHealth. All new messages display on the provider's main page within the secure Portal.

Enrollment Verification

The secure Portal offers real-time member [enrollment verification](#) for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled.
- Whether or not the member is enrolled in a state-contracted MCO (managed care organization).
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance.

Using the Portal to check enrollment may be more efficient than calling the AVR (Automated Voice Response) system or the EVS (Enrollment Verification System) (although both are available).

Providers will be assigned a unique enrollment verification number for each inquiry. Providers can also use the "print screen" function to print a paper copy of enrollment verification inquiries for their records.

Other Business Enhancements Available on the Portal

The secure Provider area of the Portal enables providers to do the following:

- Verify member enrollment.
- View RAs (Remittance Advices).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice) transaction.
- Update and maintain provider file information. Providers will have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT (electronic funds transfer).
- Track provider-submitted PA requests.

Topic #4905

Submitting Prior Authorization and Amendment Requests Via the Portal

Nearly all service areas can [submit PA \(prior authorization\)](#) requests via the ForwardHealth Portal. Providers can do the following:

- [Correct errors](#) on PAs or amendment requests via the Portal, regardless of how the PA was originally submitted.
- [View all recently submitted](#) and finalized PAs and amendment requests.
- View the latest provider review and decision letters.
- [Receive messages](#) about PA and amendment requests that have been adjudicated or returned for provider review.

Topic #4401

System and Browser Requirements

The following table lists the recommended system and browser requirements for using the ForwardHealth Portal. PES (Provider Electronic Solutions) users should note that the Windows-based requirements noted in the table apply; PES cannot be run on Apple-based systems.

Recommended System Requirements	Recommended Browser Requirements
Windows-Based Systems	
Computer with at least a 500Mhz processor, 256 MB of RAM, and 100MB of free disk space	Microsoft Internet Explorer v. 6.0 or higher, or Firefox v. 1.5 or higher
Windows XP or higher operating system	
Apple-Based Systems	
Computer running a PowerPC G4 or Intel processor, 512 MB of RAM, and 150MB of free disk space	Safari, or Firefox v. 1.5 or higher
Mac OS X 10.2.x or higher operating system	

Topic #4742

Trading Partner Portal

The following information is available on the public [Trading Partner](#) area of the ForwardHealth Portal:

- Trading partner [testing packets](#).
- [Trading Partner Profile](#) submission.
- [PES \(Provider Electronic Solutions\)](#) software and upgrade information.
- EDI (Electronic Data Interchange) [companion guides](#).

In the secure Trading Partner area of the Portal, trading partners can exchange electronic transactions with ForwardHealth.

Trading partners using PES should be sure to enter the Web logon and Web password associated with the ForwardHealth trading partner ID that will be used on PES transactions. Prior to submitting transactions through PES, trading partners must also make sure their trading partner account is entered as the "Default Provider ID" on the Switch Organization page of the secure Trading Partner account on the Portal.

Training Opportunities

Topic #12757

Training Opportunities

The [Provider Relations representatives](#) conduct training sessions in a variety of formats on both program-specific and topic-specific subjects. There is no fee for attending/accessing these training sessions.

On-Site Sessions

On-site training sessions are offered at various locations (e.g., hotel conference rooms, provider facilities) throughout the state. These training sessions include general all-provider sessions, service-specific and/or topic-specific sessions, and program-specific (such as WCDP (Wisconsin Chronic Disease Program) or the WWWP (Wisconsin Well Woman Program)) sessions.

Registration is required to attend on-site sessions. Online registration is available on the [Trainings](#) page of the Providers area of the Portal.

Online (Real-Time, Web-Based) Sessions

Online (real-time, Web-based) training sessions are available and are facilitated through [HP® Virtual Room](#). Virtual Room sessions are offered on many of the same topics as on-site sessions, but online sessions offer the following advantages:

- Participants can attend training at their own computers without leaving the office.
- Sessions are interactive as participants can ask questions during the session.
- If requested or needed, a session can be quickly organized to cover a specific topic for a small group or office.

For some larger training topics (such as ForwardHealth Portal Fundamentals), the training may be divided into individual modules, with each module focused on a particular subject. This allows participants to customize their training experience.

Registration, including an e-mail address, is required to attend Virtual Room sessions, so important session information can be sent to participants prior to the start of the session. Online registration is available on the [Trainings](#) page of the Portal.

Recorded Webcasts

Recorded Webcasts are available on a variety of topics, including some of the same topics as on-site and online sessions. Like Virtual Room sessions, some recorded Webcasts on larger training topics may be divided into individual Webcast modules, allowing participants to customize their training experience. Recorded Webcasts allow providers to view the training at their convenience on their own computers.

Registration is not required to view a recorded Webcast. Related training materials are available to download and print from the specific [Webcast training session page](#) on the Portal.

Notification of Training Opportunities

In addition to information on the Trainings page of the Portal, upcoming training session information is distributed directly through messages to providers who have secure Portal accounts and to providers who have registered for the ForwardHealth e-mail subscription service.

To sign up for a secure Portal account, click the "Request Portal Access" link in the Quick Links box on the [Provider](#) page of the Portal. To sign up for e-mail subscription, click "Register for E-mail Subscription" in the Quick Links box on the Provider page of the Portal.

Updates

Topic #4460

Full Text Publications Available

Providers may request full-text versions of *ForwardHealth Updates* to be mailed to them by calling [Provider Services](#).

Topic #478

General Information

ForwardHealth Updates are the first source of provider information. *Updates* announce the latest information on policy and coverage changes, PA (prior authorization) submission requirements, claims submission requirements, and training announcements.

The *ForwardHealth Update Summary* is posted to the ForwardHealth Portal on a monthly basis and contains an overview of *Updates* published that month. Providers with a ForwardHealth Portal account are notified through their Portal message box when the *Update Summary* is available on the Portal.

Updates included in the *Update Summary* are posted in their entirety on the Provider area of the Portal. Providers may access *Updates* from direct links in the electronic *Update Summary* as well as navigate to other Medicaid information available on the Portal.

Providers without Internet access may call [Provider Services](#) to request a paper copy of an *Update*. To expedite the call, correspondents will ask providers for the *Update* number. Providers should allow seven to 10 business days for delivery.

Revisions to policy information are incorporated into the Online Handbook in conjunction with published *Updates*. The Online Handbook also includes a link to the [ForwardHealth Publications page](#), an archive section where providers can research previously published *Updates*.

Topic #4458

Multiple Ways to Access ForwardHealth Publications

Users may register for e-mail subscription service. Providers who have established a ForwardHealth Portal account will automatically receive notification of *ForwardHealth Updates* and the monthly *ForwardHealth Update Summary* in their Portal message box. Providers will receive notification via their Portal accounts or e-mail subscription.

E-mail Subscription Service

Providers and other interested parties may register for e-mail subscription on the Portal to receive e-mail notifications of new provider publications. Users are able to select, by program (Wisconsin Medicaid, BadgerCare Plus, ADAP (Wisconsin AIDS Drug Assistance Program), or WCDP (Wisconsin Chronic Disease Program)) and provider type (e.g., physician, hospital, DME (durable medical equipment) vendor), and which publication notifications they would like to receive. Any number of staff or other interested parties from an organization may sign up for an e-mail subscription.

Users may sign up for an e-mail subscription by following these steps:

1. Click the Providers link on the [ForwardHealth Portal](#).
2. In the Quick Links section on the right side of the screen, click Register for E-mail Subscription.
3. The Subscriptions page will be displayed. In the E-Mail field in the New Subscriber section, enter the e-mail address to which messages should be sent.
4. Enter the e-mail address again in the Confirm E-Mail field.
5. Click Register. A message will be displayed at the top of the Subscriptions page indicating the registration was successful. If there are any problems with the registration, an error message will be displayed instead.
6. Once registration is complete, click the program for which you want to receive messages in the Available Subscriptions section of the Subscriptions page. The selected program will expand and a list of service areas will be displayed.
7. Select the service area(s) for which you want to receive messages. Click Select All if you want to receive messages for all service areas.
8. When service area selection is complete, click Save at the bottom of the page.
9. The selected subscriptions will load and a confirmation message will appear at the top of the page.

WiCall

Topic #257

Enrollment Inquiries

WiCall is an [AVR \(Automated Voice Response\)](#) system that allows providers with touch-tone telephones direct access to enrollment information.

Information from WiCall will be returned in the following order if applicable to the member's current enrollment:

- Transaction number: A number will be given as a transaction confirmation that providers should keep for their records.
- Benefit enrollment: All benefit plans the member is enrolled in on the DOS (date of service) or within the [DOS range selected for the financial payer](#).
- County Code: The member's county code will be provided if available. The county code is a two-digit code between 01 and 72 that represents the county in which member resides. If the enrollment response reflects that the member resides in a designated HPSA (Health Personnel Shortage Area) on the DOS or within the DOS range selected, HPSA information will be given.
- MCO (managed care organization): All information about state-contracted MCO enrollment, including MCO names and telephone numbers (that exists on the DOS or within the DOS range selected), will be listed. This information is applicable to Medicaid and BadgerCare Plus members only.
- Hospice: If the member is enrolled in the hospice benefit on the DOS or within the DOS range that the provider selected, the hospice information will be given. This information is applicable to Medicaid and BadgerCare Plus members only.
- Lock-in: Information about the [Pharmacy Services Lock-In Program](#) that exists on the DOS or within the DOS range selected will be provided. This information is applicable to Medicaid, BadgerCare Plus, and SeniorCare members only.
- Medicare: All information about Medicare coverage, including type of coverage and Medicare number, if available, that exists on the DOS or within the DOS range selected will be listed.
- Other Commercial Insurance Coverage: All information about commercial coverage, including carrier names and telephone numbers, if available, that exists on the DOS or within the DOS range selected will be listed.
- Transaction Completed: After the member's enrollment information has been given using the financial payer that was selected, providers will be given the following options:
 - To hear the information again.
 - To request enrollment information for the same member using a different financial payer.
 - To hear another member's enrollment information using the same financial payer.
 - To hear another member's enrollment information using a different financial payer.
 - To return to the main menu.

WiCall is available 24 hours a day, seven days a week. If for some reason the system is unavailable, providers may call [Provider Services](#).

Transaction Number

The AVR system issues a transaction number every time a provider verifies enrollment, even when an individual is *not* enrolled in BadgerCare Plus or Wisconsin Medicaid. The provider should retain this transaction number. It is proof that an inquiry was made about the member's enrollment. If a provider thinks a claim was denied in error, the provider can reference the transaction number to ForwardHealth to confirm the enrollment response that was actually given.

Topic #6257

Entering Letters into WiCall

For some WiCall inquiries, health care providers are required to enter their taxonomy code with their NPI (National Provider Identifier). Because taxonomy codes are a combination of numbers and letters, telephone key pad combinations, shown in the table below, allow providers to successfully enter taxonomy code letters for WiCall functions (e.g., press *21 to enter an "A," press *72 to enter an "R").

Letter	Key Combination	Letter	Key Combination
A	*21	N	*62
B	*22	O	*63
C	*23	P	*71
D	*31	Q	*11
E	*32	R	*72
F	*33	S	*73
G	*41	T	*81
H	*42	U	*82
I	*43	V	*83
J	*51	W	*91
K	*52	X	*92
L	*53	Y	*93
M	*61	Z	*12

Additionally, providers may select option 9 and press "#" for an automated voice explanation of how to enter letters in WiCall.

Topic #466

Information Available Via WiCall

WiCall, ForwardHealth's AVR (Automated Voice Response) system, gathers inquiry information from callers through voice prompts and accesses ForwardHealth interChange to retrieve and "speak" back the following ForwardHealth information:

- Claim status.
- Enrollment verification.
- PA (prior authorization) status.
- Provider CheckWrite information.

Note: ForwardHealth releases CheckWrite information to WiCall no sooner than on the first state business day following the financial cycle.

Providers are prompted to enter NPI (National Provider Identifier) or provider ID and in some cases, NPI-related data, to retrieve query information.

In all inquiry scenarios, WiCall offers the following options after information is retrieved and reported back to the caller:

- Repeat the information.
- Make another inquiry of the same type.
- Return to the main menu.

- Repeat the options.

Claim Status

Providers may check the status of a specific claim by selecting the applicable program ("financial payer" option, i.e., Wisconsin Medicaid, WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program) by entering their provider ID, member identification number, DOS (date of service), and the amount billed.

Note: Claim information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Enrollment Verification

Providers may request enrollment status for any date of eligibility the member has on file by entering their provider ID and the member ID. If the member ID is unknown, providers may enter the member's date of birth and SSN (Social Security number). Additionally, the provider is prompted to enter the "From DOS" and the "To DOS" for the inquiry. The "From" DOS is the earliest date the provider requires enrollment information and the "To" DOS must be within 365 days of the "From" DOS.

Each time a provider verifies member enrollment, the enrollment verification is saved and assigned a transaction number as transaction confirmation. Providers should note the transaction number for their records.

Prior Authorization Status

Except in certain instances, providers may obtain the status of PA requests for Medicaid and WCDP via WiCall by entering their provider ID and the applicable PA number. If the provider does not know the PA number, there is an option to bypass entering the PA number and the caller will be prompted to enter other PA information such as member ID and type of service (i.e., NDC (National Drug Code), procedure code, revenue code, or ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis code.) When a match is found, WiCall reports back the PA status information, including the PA number for future reference, and the applicable program.

Information on past PAs is retained indefinitely. Paper PAs require a maximum of 20 working days from receipt to be processed and incorporated into WiCall's PA status information.

Note: PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Topic #765

Quick Reference Guide

The WiCall [AVR \(Automated Voice Response\) Quick Reference Guide](#) displays the information available for WiCall inquiries.

Automated Voice Response Quick Reference Guide

