Certification and Ongoing Responsibilities

1

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Certification and Ongoing Responsibilities:Certification

Border Status Providers

A provider in a state that borders Wisconsin may be eligible for border-status certification. Border-status providers need to notify ForwardHealth in writing that it is common practice for members in a particular area of Wisconsin to seek their medical services.

Exceptions to this policy include:

- Nursing homes and public entities (e.g., cities, counties) outside Wisconsin are not eligible for border status.
- All out-of-state independent laboratories are eligible to be border-status providers regardless of location in the United States.

Providers who have been denied Medicaid certification in their own state are automatically denied certification by Wisconsin Medicaid unless they were denied because the services they provide are not a covered benefit in their state.

Certified border-status providers are subject to the same program requirements as in-state providers, including coverage of services and PA and claims submission procedures. Reimbursement is made in accordance with ForwardHealth policies.

For more information about out-of-state providers, refer to DHS 105.48, Wis. Admin. Code.

CLIA Certification or Waiver

Congress implemented CLIA to improve the quality and safety of laboratory services. CLIA requires *all* laboratories and providers performing tests for health assessment or for the diagnosis, prevention, or treatment of disease or health impairment to comply with specific federal quality standards.

CLIA Enrollment

The federal CMS 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 certification.

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 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. The CMS issues five types of certificates for laboratories:

1. *Waiver certificate*. This certificate allows a laboratory to perform waived tests only. The CMS Web site identifies the most current list of waived procedures. BadgerCare Plus identifies allowable waived procedures in maximum allowable fee schedules.
2. *Provider-performed microscopy procedures certificate*. This certificate allows a physician, mid-level practitioner (i.e., nurse midwife, nurse practitioner, or physician assistant licensed by the state of Wisconsin), or dentist to perform microscopy and waived procedures only. 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. *Registration certificate*. This certificate allows a laboratory to conduct moderate- or high-complexity tests until the laboratory is determined to be in compliance through a CMS survey performed by the Wisconsin state agency for CLIA.
4. *Compliance certificate*. This certificate is issued to a laboratory (for moderate- and/or high-complexity tests) after criterion performed by the state agency finds the laboratory in compliance with all applicable complexity-level requirements.
5. *Accreditation certificate*. This certificate is issued on the basis of the laboratory's accreditation by a CMS-approved accreditation organization. The six major approved accreditation organizations are:
    - JCAHO.
    - CAP.
    - COLA.
    - American Osteopathic Association.
    - American Association of Blood Banks.
    - ASHI.

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 the Clinical Laboratory Section in writing within 30 days of any change(s) in ownership, name, location, or director. Also, providers are required to notify the Clinical Laboratory Section of changes in certificate types immediately and within six months when a specialty/subspecialty is added or deleted. Providers may reach the Clinical Laboratory Section at (608) 261-0653.

Categories of Certification

Wisconsin Medicaid certifies providers in four billing categories. Each billing category has specific designated uses and restrictions. These categories include the following:

- Billing/rendering provider.
- Rendering provider.
- Group billing that requires a rendering provider.
- Group billing that does not require a rendering provider.

Providers should refer to their certification materials or to service-specific information in the Online Handbook to identify what types of certification categories they may apply for or be assigned.

Billing/Rendering Provider

Certification as 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 Provider

Certification as a rendering provider is given to those providers who practice under the professional supervision of another provider (e.g., physician assistants). Providers with a rendering provider certification cannot submit claims to ForwardHealth directly, but 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.

Group Billing

Certification as a group billing provider is issued primarily as an accounting convenience. This allows a group billing provider to receive one reimbursement, one RA, and the 835 transaction for covered services rendered by individual providers within the group.

Group Billing That Requires a Rendering Provider

Individual providers within certain groups are required to be Medicaid certified 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.

Group Billing That Does Not Require a Rendering Provider

Other groups (e.g., physician pathology, radiology groups, and rehabilitation agencies) are not required to indicate a rendering

provider on claims.

Group billing providers should refer to their certification materials or to service-specific information in the Online Handbook to determine whether or not a rendering provider is required on claims.

Certification Application

To participate in Wisconsin Medicaid, providers are required to be certified by Wisconsin Medicaid as described in DHS 105, Wis. Admin. Code. Providers certified by Wisconsin Medicaid may render services to members enrolled in Wisconsin Medicaid, BadgerCare Plus, and SeniorCare.

Providers interested in becoming certified by Wisconsin Medicaid are required to complete a provider application that consists of the following forms and information:

- General certification information.
- Certification requirements.
- TOR.
- Provider application.
- Provider Agreement and Acknowledgement of Terms of Participation.
- Other forms related to certification.

Providers may submit certification applications by mail or through the ForwardHealth Portal.

General Certification Information

This section of the provider application contains information on contacting ForwardHealth, certification effective dates, notification of certification decisions, provider agreements, and terms of reimbursement.

Certification Requirements

Wisconsin Administrative Code contains requirements that providers must meet in order to be certified with Wisconsin Medicaid; applicable Administrative Code requirements and any special certification materials for the applicant's provider type are included in the certification requirements document.

To become Medicaid certified, providers are required to do the following:

- Meet all certification requirements for their provider type.
- Submit a properly completed provider application, provider agreement, and other forms, as applicable, that are included in the certification packet.

Providers should carefully complete the certification materials and send all applicable documents demonstrating that they meet the stated Medicaid certification criteria. Providers may call Provider Services for assistance with completing these materials.

Terms of Reimbursement

Wisconsin Medicaid certification materials include Wisconsin Medicaid's TOR, which describes the methodology by which providers are reimbursed for services provided to BadgerCare Plus, Medicaid, and SeniorCare members. Providers should retain a copy of the TOR in their files. TOR are subject to change during a certification period.

Provider Application

A key part of the certification process is the completion of the Wisconsin Medicaid Provider Application. On the provider application,

the applicant furnishes contact, address, provider type and specialty, license, and other information needed by Wisconsin Medicaid to make a certification determination.

Provider Agreement and Acknowledgement of Terms of Participation

As part of the application for certification, providers are required to sign a provider agreement with the DHS. Providers applying for certification through the Portal will be required to print, sign and date, and send the provider agreement to Wisconsin Medicaid. Providers who complete a paper provider application will need to sign and date the provider agreement and submit it with the other certification materials.

By signing a provider agreement, the provider certifies that the provider and each person employed by the provider, for the purpose of providing services, holds all licenses or similar entitlements and meets other requirements specified in DHS 101 through DHS 109, Wis. Admin. Code, and required by federal or state statute, regulation, or rule for the provision of the service.

The provider's certification to participate in Wisconsin Medicaid may be terminated by the provider as provided at DHS 106.05, Wis. Admin. Code, or by the DHS upon grounds set forth in DHS 106.06, Wis. Admin. Code.

This provider agreement remains in effect as long as the provider is certified to participate in Wisconsin Medicaid.

Certification for Individual Providers Within a Clinic or Group

Individual providers within a physician clinic or group practice are required to be Medicaid certified.

Completing Certification Applications

Health care providers are required to include their NPI on the certification application.

Note: Obtaining an NPI does not replace the Wisconsin Medicaid certification process.

Portal Submission

Providers may apply for Medicaid certification directly through the ForwardHealth Portal. Though the provider certification application is available via the public Portal, the data are entered and transmitted through a secure connection to protect personal data. Applying for certification through the Portal offers the following benefits:

- Fewer returned applications. Providers who apply through the Portal are taken through a series of screens that are designed to guide them through the application process. This ensures that required information is captured and therefore reduces the instances of applications returned for missing or incomplete information.
- Instant submission. At the end of the online application process, applicants instantly submit their application to ForwardHealth and are given an ATN to use in tracking the status of their application.
- Indicates documentation requirements. At the end of the online process, applicants are also given detailed instructions about what actions are needed to complete the application process. For example, the applicant will be instructed to print the provider agreement and any additional forms that Wisconsin Medicaid must receive on paper and indicates whether supplemental information (e.g., transcripts, copy of license) is required. Applicants are also able to save a copy of the application for their records.

Paper Submission

Providers may also submit provider applications on paper. To request a paper provider application, providers should do one of the

following:

- Contact Provider Services.
- Click the "Contact Us" link on the Portal and send the request via e-mail.
- Send a request in writing to the following address:

  ForwardHealth
  Provider Maintenance
  6406 Bridge Rd
  Madison WI 53784-0006

Written requests for certification materials must include the following:

- The number of provider applications requested and each applicant's/provider's name, address, and telephone number (a provider application must be completed for each applicant/provider).
- The provider's NPI (for health care providers) that corresponds to the type of application being requested.
- The program for which certification is requested (Wisconsin Medicaid).
- The type of provider (e.g., physician, physician clinic or group, speech-language pathologist, hospital) or the type of services the provider intends to provide.

Paper provider applications are assigned an ATN at the time the materials are requested. As a result, examples of the provider application are available on the Portal for reference purposes only. These examples should not be downloaded and submitted to Wisconsin Medicaid. For the same reason, providers are not able to make copies of a single paper provider application and submit them for multiple applicants. These policies allow Wisconsin Medicaid to efficiently process and track certifications and assign effective dates.

Once completed, providers should mail certification materials to the address indicated on the application cover letter. Sending certification materials to any other Wisconsin Medicaid address may cause a delay.

Durable Medical Equipment

To be reimbursed for dispensing DME, physicians are required to obtain separate Medicaid certification as a Medical Supply and Equipment Vendor. Physicians are required to comply with all federal laws and regulations, including the Stark statute on referrals.

Effective Date of Medicaid Certification

When assigning an initial effective date, ForwardHealth follows these regulations:

1. The date the provider submits his or her online provider application to ForwardHealth or contacts ForwardHealth for a paper application is the earliest effective date possible and will be the initial effective date if the following are true:
   - The provider meets all applicable licensure, certification, authorization, or other credential requirements as a prerequisite for Wisconsin Medicaid on the date of notification. Providers should not hold their application for pending licensure, Medicare, or other required certification but submit it to ForwardHealth. ForwardHealth will keep the provider's application on file and providers should send ForwardHealth proof of eligibility documents immediately, once available, for continued processing.
   - ForwardHealth received the provider agreement and any supplemental documentation within 30 days of submission of the online provider application.
   - ForwardHealth received the paper application within 30 days of the date the paper application was mailed.
2. If ForwardHealth receives the provider agreement and any applicable supplemental documents more than 30 days after the provider submitted the online application or receives the paper application more than 30 days after the date the paper application was mailed, the provider's effective date will be the date the complete application was received at ForwardHealth.
3. If ForwardHealth receives the provider's application within the 30-day deadline described above and it is incomplete or

unclear, the provider will be granted one 30-day extension to respond to ForwardHealth's request for additional information. ForwardHealth must receive a response to the request for additional information within 30 days from the date on the letter requesting the missing information or item(s). This extension allows the provider additional time to obtain proof of eligibility (such as license verification, transcripts, or other certification).

4. If the provider does not send complete information within the original 30-day deadline or 30-day extension, the initial effective date will be based on the date ForwardHealth receives the complete and accurate application materials.

Group Certification Effective Dates

Group billing certifications are given as a billing convenience. Groups (except providers of mental health services) may submit a written request to obtain group billing certification with a certification effective date back 365 days from the effective date assigned. Providers should mail requests to backdate group billing certification to the following address:

ForwardHealth
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Request for Change of Effective Date

If providers believe their initial certification effective date is incorrect, they may request a review of the effective date. The request should include documentation that indicates the certification criteria that were incorrectly considered. Requests for changes in certification effective dates should be sent to Provider Maintenance.

Medicare Enrollment

ForwardHealth requires certain types of providers to be enrolled in Medicare as a condition for Medicaid certification. This requirement is specified in the certification materials for these provider groups.

The enrollment process for Medicare is separate from Wisconsin Medicaid's certification process. Providers applying for Medicare enrollment *and* Medicaid certification are encouraged to apply for Wisconsin Medicaid certification at the same time they apply for Medicare enrollment, even though Medicare enrollment must be finalized first. By applying for Medicare enrollment and Medicaid certification simultaneously, it may be possible for ForwardHealth to assign a Medicaid certification effective date that is the same as the Medicare enrollment date.

Express Enrollment for Pregnant Women Benefit

Physicians, physician assistants, nurse practitioners, and nurse midwives may become Medicaid-certified EE 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.

HealthCheck

Physicians who are Wisconsin Medicaid certified with a specialty of family practice, general practice, internal medicine, or pediatrics and nurse practitioners who are Medicaid certified with a specialty of certified pediatric nurse practitioner and certified family nurse practitioner are automatically certified as HealthCheck (EPSDT) screeners at the time of initial Medicaid certification and recertification. Providers (physicians and nurse practitioners with other specialties and physician assistants) who are interested in becoming HealthCheck screeners may apply for HealthCheck screener Medicaid certification by completing the appropriate certification packet.

Materials for New Providers

On an ongoing basis, providers should refer to the Online Handbook for the most current BadgerCare Plus and Medicaid information. Future changes to policies and procedures are published in *Updates*.

Certain providers may opt not to receive these materials by completing the Deletion from Publications Mailing List form in the certification materials. Providers who opt out of receiving publications are still bound by ForwardHealth's rules, policies, and regulations even if they choose not to receive *Updates* on an ongoing basis. *Updates* are available for viewing and downloading on the ForwardHealth Portal.

Multiple Locations

The number of Medicaid certifications allowed or required per location is based on licensure, registration, certification by a state or federal agency, or an accreditation association identified in the Wisconsin Administrative Code. Providers with multiple locations should inquire if multiple applications must be completed when requesting a Medicaid certification application.

Multiple Services

Providers who offer a variety of services may be required to complete a separate Medicaid certification packet for each specified service/provider type.

Health care providers who are federally required to have an NPI are responsible for obtaining the appropriate certification for their NPI.

If a Medicaid-certified provider begins offering a new service *after* he or she has become initially certified, it is recommended that he or she call Provider Services to inquire if another application must be completed.

Noncertified In-State Providers

Wisconsin Medicaid reimburses noncertified in-state providers for providing emergency medical services to a member or providing services to a member during a time designated by the governor as a state of emergency. The emergency situation or the state of emergency must be sufficiently documented on the claim. Reimbursement rates are consistent with rates for Wisconsin Medicaid-certified providers rendering the same service.

Claims from noncertified in-state providers must be submitted with an In-State Emergency Provider Data Sheet. The In-State Emergency Provider Data Sheet provides ForwardHealth with minimal tax and licensure information.

Noncertified in-state providers may call Provider Services with questions.

Notice of Certification Decision

Wisconsin Medicaid will notify the provider of the status of the certification usually within 10 business days, but no longer than 60 days, after receipt of the complete application for certification. Wisconsin Medicaid will either approve the application and issue the certification or deny the application. If the application for certification is denied, Wisconsin Medicaid will give the applicant reasons, in writing, for the denial.

Providers who meet the certification requirements will be sent a welcome letter and a copy of the signed provider agreement. Included with the letter is an attachment with important information such as effective dates, assigned provider type and specialty, and taxonomy code. This information will be used when conducting business with BadgerCare Plus, Medicaid, or SeniorCare (for example, health

care providers will need to include their taxonomy code, designated by Wisconsin Medicaid, on claim submissions and requests for PA).

The welcome letter will also notify non-healthcare providers (e.g., SMV providers, personal care agencies, blood banks) of their Medicaid provider number. This number will be used on claim submissions, PA requests, and other communications with ForwardHealth programs.

Nurse Practitioners

Nurse practitioners who treat ForwardHealth members are required to be Medicaid certified to receive reimbursement. This applies to nurse practitioners whose services are reimbursed under a physician's or clinic's NPI, as well as to those who independently submit claims to Wisconsin Medicaid.

To be certified by Wisconsin Medicaid, a nurse practitioner must be licensed as a registered nurse pursuant to s. 441.06, Wis. Stats. Nurse practitioners are eligible for Medicaid certification if they meet one of the following criteria:

- Are a pediatric nurse practitioner, family nurse practitioner, or other nurse practitioner *and* certified by one of the following national certifying organizations recognized by the Wisconsin Department of Regulation and Licensing:
    - American Nurses Credentialing Center.
    - National Certification Board of Pediatric Nurse Practitioners and Nurses.
    - American Academy of Nurse Practitioners.
    - National Certification Corporation (for Obstetric, Gynecologic, and Neonatal Nursing Specialists).
- Are a Master's degree-prepared nurse in a clinical nurse specialty other than mental health (e.g., nurse midwife, clinical nurse specialist, or nurse practitioner).

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 certification are certified 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-certified 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 certification is not required for nurse practitioners working in a 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 certification 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 reimbursement, *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-certified nurse practitioners pursuant to N 6.03(1), Wis. Admin. Code.

Out-of-State Providers

Out-of-state providers are limited to those providers who are licensed in the United States (and its territories), Mexico, and Canada. Out-of-state providers are required to be licensed in their own state of practice.

Wisconsin Medicaid reimburses out-of-state providers for providing emergency medical services to a BadgerCare Plus or Medicaid member or providing services to a member during a time designated by the governor as a state of emergency. The emergency situation or the state of emergency must be sufficiently documented on the claim. Reimbursement rates are consistent with rates for Wisconsin Medicaid-certified providers providing the same service.

Out-of-state providers are reimbursed for services provided to eligible BadgerCare Plus or Medicaid members in either of the following situations:

- The service was provided in an emergency situation, as defined in DHS 101.03(52), Wis. Admin. Code.
- PA was obtained from ForwardHealth *before* the nonemergency service was provided.

Claims from noncertified out-of-state providers must be submitted with an Out-of-State Provider Data Sheet. The Out-of-State Provider Data Sheet provides Wisconsin Medicaid with minimal tax and licensure information.

Out-of-state providers may contact Provider Services with questions.

Physician Assistants

To be Medicaid-certified, physician assistants are required to be licensed and registered pursuant to s. 448.05 and 448.07, Wis. Stats., and chs. Med 8 and 14, Wis. Admin. Code. All physician assistants are required to be individually certified by Wisconsin Medicaid for their services to be reimbursed.

Physician assistants cannot independently submit claims to ForwardHealth. Claims for services provided by a physician assistant must be submitted with the physician assistant's NPI as the rendering provider and the supervising physician's or the clinic's NPI as the billing provider.

Physicians and Residents

To be certified by Wisconsin Medicaid, physicians and residents are required to be licensed to practice medicine and surgery pursuant

to s. 448.05 and 448.07, Wis. Stats., and chs. Med 1, 2, 3, 4, 5, and 14, Wis. Admin. Code.

Physicians are asked to identify their practice specialty at the time of Medicaid certification. Reimbursement for certain services is limited to physicians with specific specialties.

To be reimbursed for psychiatric services (CPT codes 90801-90857, 90865-90899), physicians are required to be certified as a psychiatrist pursuant to DHS 105.22(1)(a), Wis. Admin. Code. Any Medicaid-certified physician may be reimbursed for substance abuse services.

Physician services providers who perform other services may refer to those areas of the Online Handbook for more information about coverage limitations for other services and call Provider Services to obtain certification packets.

Prenatal Care Coordinators

PNCC services help pregnant women who are identified as being at high risk for negative birth outcomes gain access to, coordinate, and follow up on necessary medical, social, educational, and other services.

DHS 105.52(1), Wis. Admin. Code, defines the following types of providers and agencies as eligible for Medicaid certification as PNCC providers:

- A community-based health organization.
- A community-based social services agency or organization.
- A county, city, or combined city and county public health agency.
- A county department of human services under s. 46.23, Wis. Stats., or social services under s. 46.215 or s. 46.22, Wis. Stats.
- A family planning agency certified under DHS 105.36, Wis. Admin. Code.
- An FQHC as defined in 42 CFR 405.2401(b).
- An HMO.
- An IPA.
- A hospital.
- A physician's office or clinic.
- A private case management agency.
- A certified nurse or nurse practitioner.
- An RHC certified under DHS 105.35, Wis. Admin. Code.
- A tribal agency health center.
- A WIC program under 42 USC 1786.

For Medicaid certification as a PNCC service provider, qualified agencies must submit a comprehensive agency outreach and care management plan to Wisconsin Medicaid for approval.

Provider Addresses

ForwardHealth interChange has the capability of storing the following types of addresses and related information, such as contact information and telephone numbers:

- *Practice location address and related information (formally known as physical address).* 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 telephone number for member's use. With limited exceptions, the practice location and telephone number for member's 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 concise address information to aid in proper mail delivery.
- *PA address.* This address is where ForwardHealth will mail PA information.
- *Financial addresses (formally known as payee address).* Two separate financial addresses are stored in ForwardHealth

interChange. The checks address is where Wisconsin Medicaid will mail paper checks. The 1099 mailing address is where Wisconsin Medicaid will mail IRS Form 1099.

Providers may submit additional address information or modify their current information through the ForwardHealth Portal or by using the Provider Change of Address or Status form.

Note: Providers are cautioned that any changes to their practice location on file with ForwardHealth 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.

Provider addresses are stored separately for each program (i.e., Medicaid, WCDP, and WWWP) for which the provider is certified. Providers should consider this when supplying additional address information and keeping address information current. Providers who are certified for multiple programs and have an address change that applies to more than one program should provide this information for each program. Providers who submit these changes on paper need to submit *one* Provider Change of Address or Status form if changes are applicable for multiple programs.

Provider Type and Specialty Changes

Providers who want to add a certification type or make a change to their certification type should call Provider Services.

Health care providers who are federally required to have an NPI are cautioned that any changes to their provider type and/or specialty information on file with ForwardHealth may alter the applicable taxonomy code for a provider's certification.

Reinstating Certification

Providers whose Medicaid certification has ended for any reason other than sanctions or failure to be recertified may have their certification reinstated as long as all licensure and certification requirements are met. The criteria for reinstating certification vary, depending upon the reason for the cancellation and when the provider's certification ended.

If it has been less than 365 days since a provider's certification has ended, the provider is required to submit a letter or the Provider Change of Address or Status form, stating that he or she wishes to have his or her Medicaid certification reinstated.

If it has been more than 365 days since a provider's certification has ended, the provider is required to submit new certification materials. This can be done by completing them through the ForwardHealth Portal or submitting a paper provider application.

Temporary Enrollment for Family Planning Only Services

Providers qualified to make TE 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.

Tracking Certification Materials

Wisconsin Medicaid allows providers to track the status of their certification application either through the ForwardHealth Portal or by calling Provider Services. Providers who submitted their application through the Portal will receive the ATN upon submission, while providers who request certification materials from Wisconsin Medicaid will receive an ATN on the application cover letter sent with their provider application. Regardless of how certification materials are submitted, providers may use one of the methods listed to track the status of their certification application.

Note: Providers are required to wait for the Notice of Certification Decision as official notification that certification has been

approved. This notice will contain information the provider needs to conduct business with BadgerCare Plus, Medicaid, or SeniorCare; therefore, an approved or enrolled status alone does not mean the provider may begin providing or billing for services.

Tracking Through the Portal

Providers are able to track the status of a certification application through the Portal by entering their ATN. Providers will receive current information on their application, such as whether it's being processed or has been returned for more information.

Tracking Through Provider Services

Providers may also check on the status of their submitted application by contacting Provider Services and giving their ATN.

Documentation

1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than $600.00, per 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 share the same tax identification number. For example, a provider who conducts business with both Medicaid and WCDP will receive separate 1099 Miscellaneous forms for each program.

The 1099 Miscellaneous forms are sent to the address designated as the "1099 mailing address." The address formerly known as the "payee address" is used as the 1099 mailing address unless a provider has reported a separate address for the 1099 mailing address to ForwardHealth.

Availability of Records to Authorized Personnel

The DHCAA 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 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, including HMOs and SSI HMOs, are not reimbursed for the reproduction costs covered in their contract with the DHS.

The reproduction of records requested by the PRO under contract with the DHCAA is reimbursed at a rate established by the PRO.

Confidentiality

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. Therefore, use or disclosure of any information concerning applicants and members for any purpose not connected with program administration, including contacts with third-party payers that are necessary for pursuing third-party payment and the release of information as ordered by the court, is prohibited unless authorized by the applicant or member.

To comply with the standards, providers are required to follow the procedures outlined in the Online Handbook to ensure the proper release of this information. ForwardHealth providers, like other health care providers, are also subject to other laws protecting confidentiality of health care information including, but not limited to, the following:

- s. 146.81-146.84, Wis. Stats., Wisconsin health care confidentiality of health care information regulations.
- 42 USC s. 1320d - 1320d-8 (federal HIPAA) and accompanying regulations.

Any person violating this regulation may be fined an amount from $25 up to $500 or imprisoned in the county jail from 10 days up to one year, or both, for each violation.

A provider is not subject to civil or criminal sanctions when releasing records and information regarding applicants or members if such release is for purposes directly related to administration or if authorized in writing by the applicant or member.

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.

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.

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 not 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. Members who are enrolled on the date of the records request may obtain one free copy of each document in their record. This applies regardless of the member's enrollment status on the DOS 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.

For information regarding fees that may be charged to members for health care records, such as paper copies, microfiche, and X-rays beyond the first set of copies, refer to s. 146.83(1f), Wis. Stats.

Fee Refunds

If a provider has collected a fee for the first set of copies of health care records provided to an enrolled member, and the member requests a refund, the provider is required to refund the fee to the member.

Preparation and Maintenance of Records

All providers who receive payment from Wisconsin Medicaid, including state-contracted MCOs, 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.

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, who 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.

Reviews and Audits

The DHS 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.

Records Requests

Requests for billing or medical claim information regarding services reimbursed by BadgerCare Plus 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 BadgerCare Plus.

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, 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-certified 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.

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 or the federal HHS to perform any function related to program administration, such as auditing, program monitoring, and evaluation.

Providers are authorized under BadgerCare Plus 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

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).

Change in Ownership

New certification 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 certification for Wisconsin Medicaid certification change in ownerships:

- Ambulatory surgery centers.
- ESRD services providers.
- Federally qualified health centers.
- Home health agencies.
- Hospice providers.
- Hospitals (inpatient and outpatient).
- Nursing homes.
- Outpatient rehabilitation facilities.
- Rehabilitation agencies.
- RHCs.

All changes in ownership must be reported in writing to ForwardHealth and new certification 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 certification effective date in the mail.

Providers with questions about change in ownership should call Provider Services.

Repayment Following Change in Ownership

Medicaid-certified 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 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.

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 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 at no cost to the LEP individual in order to provide meaning 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 Affirmative Action and Civil Rights Compliance Plan requirements. Providers that employ less than 25 employees and receive less than $25,000 annually in Medicaid reimbursement are required to comply by submitting a Letter of Assurance and other appropriate forms.

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

AA/CRC Office
1 W Wilson St Rm 561

PO Box 7850
Madison WI 53707-7850

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

Title VI of the Civil Rights Act of 1964

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

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

Title VII of the Civil Rights Act of 1964

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

Federal Rehabilitation Act of 1973, Section 504

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

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

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

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

Americans with Disabilities Act of 1990

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

1. Remove barriers to make 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.

Contracted Staff

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

When contracting services, providers are required to monitor the contracted agency to ensure that the agency is meeting member needs and adhering to ForwardHealth requirements.

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

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

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

Examples of Ongoing Responsibilities

Responsibilities for which providers are held accountable are described throughout the Online Handbook. Medicaid-certified 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 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 recertification notifications.

- Safeguarding member confidentiality.
- Verifying member enrollment.
- Keeping up-to-date with changes in program requirements as announced in ForwardHealth publications.

Keeping Information Current

Types of Changes

Providers are required to notify ForwardHealth of changes, including the following:

- Address(es) — practice location and related information, mailing, PA, and/or financial.
- Telephone number, including area code.
- Business name.
- Contact name.
- Federal Tax ID number (IRS number).
- Group affiliation.
- Licensure.
- Medicare NPI for health care providers or Medicare provider number for providers of *non-healthcare* services.
- Ownership.
- Professional certification.
- Provider specialty.
- Supervisor of nonbilling providers.

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

- Incorrect reimbursement.
- Misdirected payment.
- Claim denial.
- Suspension of payments in the event that provider mail is returned to ForwardHealth for lack of a current address.

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

Address Changes

Healthcare providers who are federally required to have an NPI are cautioned that changes to their practice location address on file with ForwardHealth may alter their ZIP+4 code information that is required on transactions.

Submitting Changes in Address or Status

Once certified, providers are required to submit changes in address or status as they occur, either through the Portal or on paper.

ForwardHealth Portal Submission

After establishing a provider account on the ForwardHealth Portal, providers may make changes to their demographic information online. Changes made through the Portal instantly update the provider's information in ForwardHealth interChange. In addition, since the provider is allowed to make changes directly to his or her information, the process does not require re-entry by ForwardHealth.

Providers should note, however, that the demographic update function of the Portal limits certain providers from modifying some types of information. Providers who are not able to modify certain information through the Portal may make these changes using the Provider Change of Address or Status form.

Paper Submission

Providers must use the Provider Change of Address or Status form. Copies of old versions of this form will not be accepted and will be returned to the provider so that he or she may complete the current version of the form or submit changes through the Portal.

Change Notification Letter

When a change is made to certain provider information, either through the use of the Provider Change of Address or Status form or through the Portal, ForwardHealth will send a letter notifying the provider of the change(s) made. Providers should carefully review the Provider File Information Change Summary included with the letter. If any information on this summary is incorrect, providers may do one of the following:

- If the provider made an error while submitting information on the Portal, he or she should correct the information through the Portal.
- If the provider submitted incorrect information using the Provider Change of Address or Status form, he or she should either submit a corrected form or correct the information through the Portal.
- If the provider submitted correct information on the Provider Change of Address or Status form and believes an error was made in processing, he or she can contact Provider Services to have the error corrected or submit the correct information via the Portal.

Notify Division of Quality Assurance of Changes

Providers licensed or certified by the DQA are required to notify the DQA of changes to physical address, changes of ownership, and facility closures by calling (608) 266-8481.

Providers licensed or certified by the DQA are required to notify the DQA of these changes *before* notifying ForwardHealth. The DQA will then forward the information to ForwardHealth.

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. Within the DHS, the DHCAA is directly responsible for managing these programs.

Prescription

Disposable Medical Supplies and Durable Medical Equipment

All DME and DMS 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 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 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-certified DME provider or pharmacy. Wisconsin Medicaid does not reimburse prescribing providers for supplying breast pumps, unless they are also Medicaid certified as a DME provider or a pharmacy.

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 number of the prescriber on all prescriptions. DEA numbers are not required on claims or PAs.

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.

Opioid Monthly Prescription Fill Limit

Opioid drugs are limited to five prescription fills per calendar month for members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, the BadgerCare Plus Basic Plan, Wisconsin Medicaid, and SeniorCare.

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 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.
- Member's name and ID.
- Pharmacy's name and telephone number where the member attempted to have the prescription filled.
- Date the prescription was attempted to be filled.
- Drug name, strength, and quantity.
- Instructions for use.

The DAPO Center will provide information to the prescriber regarding the member's recent medication history.

If the prescriber determines an override is medically necessary, the DAPO Center will record the override, and the prescriber should contact the member and the pharmacy. When contacting the member, the prescriber should use this opportunity to discuss the appropriate use of opioids.

If the prescriber decides that it is not medically necessary to override the opioid monthly prescription fill limit, the prescriber should contact the member and discuss follow-up care. If the override is not given, the prescriber should contact the pharmacy to have the

prescription canceled.

Pharmacy Responsibilities

When pharmacies are contacted by a prescriber and notified that an override is available, the pharmacy should submit the claim for the opioid. Pharmacies are responsible for submitting claims for opioids within three days of the override being obtained by the prescriber. If the pharmacy provider does not submit the claim within the three day time period, the claim will be denied.

Note: If the pharmacy provider contacts the DAPO Center to obtain an override, the DAPO Center will inform the pharmacy provider that the prescriber is responsible for obtaining the override.

If a prescriber does not override the opioid monthly prescription fill limit for members enrolled in the Standard Plan, Medicaid, or SeniorCare, the service is considered noncovered.

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

Exceptions

Opioid prescription fill limit exceptions are covered for members enrolled in the Standard Plan, Medicaid, and SeniorCare.

Members enrolled in the Benchmark Plan, the Core Plan, and the Basic Plan are not eligible to receive an opioid prescription fill limit exception.

Schedule III-V drugs

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

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contact the prescriber (or the prescriber's agent) but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacy must document on the prescription order that the prescriber is not available.
- The pharmacist confirmed that dispensing a 96-hour supply is medically necessary.
- A 96-hour supply exception was not previously granted within the current calendar month.

If the prescriber is unavailable and the DAPO Center is closed, then pharmacy providers may dispense a 96 hour supply if the following conditions are met:

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contact the prescriber (or the prescriber's agent), but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacy must document on the prescription order that the prescriber is not available.
- The pharmacist confirmed that dispensing a 96-hour supply is medically necessary.
- A 96-hour supply exception was not previously granted within the current calendar month.

Only one 96-hour supply exception for opioid drugs is allowed per calendar month. Once the DAPO Center is open, the pharmacy must call to obtain the 96-hour supply exception.

The 96-hour supply exception may be retroactive up to five days (i.e., back dated).

If a 96-hour supply exception has already been provided in the same calendar month, the prescription is a noncovered service.

Schedule II Drugs

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

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contacted the prescriber (or the physician's agent), but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacy must document on the prescription order that the prescriber is not available.
- The pharmacist confirmed that it is medically necessary to dispense the drug.
- An exception for Schedule II drugs was not previously granted within the current calendar month.
- The pharmacist may dispense the full quantity indicated on the prescription order.

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

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contact the prescriber (or the physician's agent), but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacy documented on the prescription order that the prescriber is not available.
- The pharmacist confirmed that it is medically necessary to dispense the drug.
- The pharmacist may dispense the full quantity indicated on the prescription order.

Pharmacy providers are required to submit a Noncompound Drug Claim form, with a Pharmacy Special Handling Request 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.

Prescriber Information for Drug Prescriptions

Most legend and certain OTC 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.
- PA.
- 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.

Contraceptives

Contraceptives are covered for females who are 10 through 65 years of age. Quantity limits, age-restrictions, and gender-restrictions apply to contraceptives.

ForwardHealth has adopted the gender restriction coding from First DataBank. The gender restrictions are automatically updated by First DataBank.

Preferred Drug List

Most preferred drugs on the PDL do *not* require PA, although these drugs may have other restrictions (e.g., age, diagnosis); non-preferred drugs *do* require PA. Prescribers are encouraged to write prescriptions for preferred drugs; however, a PA process is available for non-preferred drugs if the drugs are medically necessary. Prescribers are encouraged to try more than one preferred drug, if medically appropriate for the member, before prescribing a non-preferred drug.

Prescriber Responsibilities for Non-preferred Drugs

Prescribers should determine the ForwardHealth benefit plan in which a member is enrolled before writing a prescription. If a member is enrolled in the BadgerCare Plus Standard Plan, Medicaid, or SeniorCare, prescribers are encouraged to write prescriptions for preferred drugs. Prescribers are encouraged to prescribe more than one preferred drug before a non-preferred drug is prescribed.

If a non-preferred drug or a preferred drug that requires clinical PA is medically necessary for a member, the prescriber is required to complete a PA request for the drug. Prescribers are required to complete the appropriate PA form and submit it to the pharmacy provider where the prescription will be filled. When completing the PA form, prescribers are reminded to sign and date the form. PA request forms may be faxed or mailed to the pharmacy provider, or the member may carry the form with the prescription to the pharmacy provider. The pharmacy provider will use the completed form to submit a PA request to ForwardHealth. The prescriber is required to attest on the form that the member meets the clinical criteria for PA approval. Prescribers should not submit PA forms to ForwardHealth.

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

For BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, and BadgerCare Plus Basic Plan members, prescribers should be aware of drugs covered by the benefit plan and write prescriptions for drugs that are covered by the plan.

If a noncovered drug is medically necessary for a Benchmark Plan, Core Plan, or Basic Plan member, the prescriber should inform the member the drug is not covered by the benefit plan. The prescriber should instruct the member to work with his or her pharmacy provider to determine whether or not the drug is covered by BadgerRx Gold.

Diagnosis-Restricted Drugs

Prescribers are required to include a diagnosis description on prescriptions for those drugs that are diagnosis-restricted.

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

By federal law, pharmaceutical manufacturers who participate in state Medicaid programs must sign a rebate agreement with the CMS. 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-certified 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-approved legend drugs through the PA process even though the drug manufacturers did not sign rebate agreements.

To submit a PA request for a drug without a signed rebate agreement, the prescriber should complete and submit the PA/DGA to the pharmacy where the drug will be dispensed. Pharmacies should complete the PA/RF and submit both forms and any supporting documentation to ForwardHealth. PAs can be submitted by paper, fax, or on the ForwardHealth Portal.

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

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

If a PA request for a drug without a signed manufacturer rebate is approved, claims for drugs without a signed rebate agreement must be submitted on paper. Providers should complete and submit the Noncompound Drug Claim indicating the actual NDC of the drug with the Pharmacy Special Handling Request Form.

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

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.

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 National Drug Code List, BadgerCare Plus Core Plan National Drug Code List, BadgerCare Plus Basic Plan National Drug Code List, and the BadgerCare Plus Core Plan Brand Name Drugs — Quick Reference. 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 (42 CFR Parts 456.703 and 456.705) called for a DUR program for all Medicaid-covered drugs to improve the quality and cost-effectiveness of member care. ForwardHealth's prospective DUR system assists pharmacy providers in screening

certain drug categories for clinically important potential drug therapy problems before the prescription is dispensed to the member. The DUR system checks the member's entire drug history regardless of where the drug was dispensed or by whom it was prescribed.

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

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

Prospective Drug Utilization Review's Impact on Prescribers

If a pharmacist receives an alert, a response is required before the drug can be dispensed to the member. This may require the pharmacist to contact the prescriber for additional information to determine if the prescription should be filled as written, modified, or cancelled. Prescribers should respond to inquiries, such as telephone calls or faxes, related to prescribed drugs from pharmacy providers.

Drugs with Three-Month Supply Requirement

ForwardHealth has identified a list of drugs for which pharmacy providers are required to dispense a three-month supply. The same list includes drugs that may be (but are not required to be) dispensed in a three-month supply.

Member Benefits

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

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

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

Prescription Quantity

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

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

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

Prescription Mail Delivery

Current Wisconsin law permits Wisconsin Medicaid-certified retail pharmacies to deliver prescriptions to members via the mail. Wisconsin Medicaid-certified 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 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. 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.

ePocrates

Providers may also access the Medicaid, BadgerCare Plus, and SeniorCare PDL through ePocrates. ePocrates' products provide clinical reference information specifically for health care providers to use at the point of care. Prescribers and pharmacy providers (e.g., pharmacies, dispensing physicians, FQHCs, blood banks) who use PDAs can subscribe and download the PDL from the ePocrates' Web site.

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

As of October 1, 2008, to be considered tamper-resistant, federal law requires that prescription pads/paper contain all three of the following characteristics:

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

Exclusions to Tamper-Resistant Prescription Pad Requirement

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

- Prescriptions faxed directly from the prescriber to the pharmacy.
- Prescriptions electronically transmitted directly from the prescriber to the pharmacy.
- Prescriptions telephoned directly from the prescriber to the pharmacy.
- Prescriptions provided to members in nursing facilities, intermediate care facilities for the mentally retarded, and other specified institutional and clinical settings to the extent that drugs are part of their overall rate. However, written prescriptions filled by a pharmacy outside the walls of the facility are subject to the tamper-resistant requirement.

Obtaining Free Prescription Pads

The Wisconsin DHS has made available a limited supply of free prescription pads through its contracted vendor, Standard Register. Medicaid-certified prescribers may request up to five free prescription pads. There is a limited supply of the free pads available, and they will be distributed as requests are received. Providers are required to pay the shipping costs for the free pads.

Providers are not required to use the state-supplied prescription pads to be compliant with the tamper-resistant prescription pad requirement.

To request the free tamper-resistant prescription pads, providers must complete and submit an order form to Standard Register. The order form is available for download from the Standard Register Web site. Completed orders may be faxed or placed over the telephone to Standard Register at the following numbers:

- Fax — (866) 869-3971.
- Telephone — (866) 741-8488.

72-Hour Grace Period

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

Coordination of Benefits

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

Retroactive Medicaid Eligibility

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

Penalty for Noncompliance

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

Provider Numbers

National Provider Identifier

Health care providers are required to indicate an NPI on electronic and paper transactions submitted to ForwardHealth.

The NPI is a 10-digit number obtained through NPPES.

Providers should ensure that they have obtained an appropriate NPI to correspond to their certification.

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 certifications — one certification as an individual physical therapist and the other certification as the physical therapy group. A Type 1 NPI for the individual certification and a Type 2 NPI for the group certification are required.

NPIs and classifications may be viewed on the NPPES Web site. The CMS Web site includes more Type 1 and Type 2 NPI information.

Some providers hold multiple certifications with ForwardHealth. For example, a health care organization may be certified according to the type of services their organization provides (e.g., physician group, therapy group, home health agency) or the organization may have separate certification for each practice location. ForwardHealth maintains a separate provider file for each certification that stores information used for processing electronic and paper transactions (e.g., provider type and specialty, certification begin and end dates). When a single NPI is reported for multiple certifications, ForwardHealth requires additional data to identify the provider and to determine the correct provider file to use when processing transactions.

Either or both of the following additional data is required with NPI when a single NPI corresponds to multiple certifications:

- The ForwardHealth-designated taxonomy code.
- ZIP+4 code (complete, nine digits) that corresponds to the practice location address on file with ForwardHealth.

Omission of the additional required data will cause claims and other transactions to be denied or delayed in processing.

Supervisor Changes for Nonbilling Providers

For supervisor changes, physician assistants are required to complete the Declaration of Supervision for Nonbilling Providers.

Taxonomy Codes

Taxonomy codes are standard code sets used to provide information about provider type and specialty for the provider's certification. Providers are required to use the taxonomy code designated by ForwardHealth when the NPI reported to ForwardHealth corresponds to multiple certifications and the provider's practice location ZIP+4 code does not uniquely identify the provider.

ForwardHealth designates a taxonomy code as additional data to be used to correctly match NPI to the correct provider file. The

designated taxonomy code may be different than the taxonomy code providers originally submitted to NPPES when obtaining their NPI as not all national taxonomy code options are recognized by ForwardHealth. For example, some taxonomy codes may correspond to provider types not certifiable with ForwardHealth, or they may represent services not covered by ForwardHealth.

Omission of a taxonomy code when it is required as additional data to identify the provider or indicating a taxonomy code that is not designated by ForwardHealth will cause claims and other transactions to be denied or delayed in processing.

Refer to the ForwardHealth-designated taxonomy codes for the appropriate taxonomy code for your certification.

Note: The ForwardHealth-designated taxonomy code does not change provider certification or affect reimbursement terms.

ZIP Code

The ZIP+4 code is the ZIP code of a provider's practice location address on file with ForwardHealth. Providers are required to use the ZIP+4 code when the NPI reported to ForwardHealth corresponds to multiple certifications and the designated taxonomy code does not uniquely identify the provider.

Omission of the ZIP+4 code of the provider's practice location address when it is required as additional data to identify the provider 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

A Comprehensive Overview of Provider Rights

Medicaid-certified 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 methods, including calling Provider Services.

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
6406 Bridge Rd
Madison WI 53784-0006

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.

Hearing Requests

A provider who wishes to contest a DHS action or inaction for which due process is required under s. 227, Wis. Stats., may request a hearing by writing to the DHA.

A provider who wishes to contest the DHCAA's 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.

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.

Requesting Discretionary Waivers and Variances

In rare instances, a provider or member may apply for, and the DHCAA 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 HFS 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, 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

Recertification

An Overview

Each year approximately one-third of all Medicaid-certified providers undergo recertification. During provider recertification, providers update their information and sign the Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation. Providers are required to complete the provider recertification process to continue their participation with Wisconsin Medicaid. For most providers, recertification will be conducted online at the ForwardHealth Portal. Providers will be notified when they need to be recertified and will be provided with instructions on how to complete the recertification process.

Checking the Status of a Recertification Application

Providers may check the status of their recertification on the ForwardHealth Portal by entering the ATN from the Provider Recertification Notice and pressing "Search."

Providers will receive one of the following status responses:

- "Approved." ForwardHealth has reviewed the recertification materials and all requirements have been met. ForwardHealth is completing updates to provider files.
- "Awaiting Additional Info." ForwardHealth has reviewed the recertification materials and has requested additional information from the provider. Providers will receive a letter via mail when additional materials or information are required to complete processing of the recertification materials.
- "Awaiting Follow-On Documents." ForwardHealth requires additional paper documents to process the recertification. After the provider has submitted recertification information online via the Portal, the final screen will list additional documents the provider must mail to ForwardHealth. ForwardHealth cannot complete processing until these documents are received. This status is primarily used for SMV provider recertification.
- "Denied." The provider's recertification has been denied.
- "Failure to Recertify." The provider has not recertified by the established recertification deadline.
- "In Process." The recertification materials are in the process of being reviewed by ForwardHealth.
- "Paper Requested." The provider requested a paper recertification application and ForwardHealth has not received the paper application yet.
- "Recert Initiated." The Provider Recertification Notice and PIN letter have been sent to the provider. The provider has not started the recertification process yet.
- "Recertified." The provider has successfully completed recertification. There are no actions necessary by the provider.
- "Referred To DHS." ForwardHealth has referred the provider recertification materials to the State Certification Specialist for recertification determination.

Notification Letters

Providers undergoing recertification will receive two important letters in the mail from ForwardHealth:

- The Provider Recertification Notice. This is the first notice to providers. The Provider Recertification Notice contains identifying information about the provider who is required to complete recertification, the recertification deadline, and the ATN assigned to the provider. The ATN is used when logging in to the ForwardHealth Portal to complete recertification and also serves as the tracking number when checking the status of the provider's recertification.
- The PIN letter. Providers will receive this notice a few days after the Provider Recertification Notice. The PIN letter will contain a recertification PIN and instructions on logging in to the Portal to complete recertification.

The letters are sent to the mailing address on file with Wisconsin Medicaid. Providers should read these letters carefully and keep them

for reference. The letters contain information necessary to log in to the secure Recertification area of the Portal to complete recertification. If a provider needs to replace one of the letters, the recertification process will be delayed.

Paper Recertification Applications

Providers who do not have Internet access or who are not able to complete recertification via the ForwardHealth Portal should contact Provider Services to request a paper recertification application. Providers who request a paper application are required to complete the recertification process on paper and not online via the Portal to avoid duplicate recertification submissions.

Recertification Completed by an Authorized Representative

A provider has several options for submitting information to the DHS, including electronic and Web-based submission methodologies that require the input of secure and discrete access codes but not written provider signatures.

The provider has sole responsibility for maintaining the privacy and security of any access code the provider uses to submit information to the DHS, and any individual who submits information using such access code does so on behalf of the provider, regardless of whether the provider gave the access code to the individual or had knowledge that the individual knew the access code or used it to submit information to the DHS.

Recertification on the ForwardHealth Portal

Logging in to the Secure Recertification Area of the Portal

Once a provider has received the Provider Recertification Notice and PIN letter, the provider may log in to the Recertification area of the ForwardHealth Portal to begin the recertification process.

The Recertification area of the Portal is not part of a Provider Portal account. Providers do not need a Provider Portal account to participate in recertification via the Portal. Providers are not able to access the Recertification area of the Portal by logging in to a Provider Portal account; providers must use the ATN from the Provider Recertification Notice and PIN from the PIN letter to log in to the Recertification area of the Portal.

The Portal will guide providers through the recertification process. On each screen, providers are required to complete or verify information.

Completing Recertification

Providers are required to complete all of the recertification screens in a single session. The Portal will not save a provider's partial progress through the recertification screens. If a provider does not complete all of the recertification screens in a single session, the provider will be required to start over when logging in to the Recertification area of the Portal again.

It is important to read the final screen carefully and follow all instructions before exiting the recertification process. After exiting the recertification process, providers will not be able to retrieve the provider recertification documents for their records.

The final screen of the recertification process gives providers the option to print and save a PDF version of the recertification information submitted to ForwardHealth. Providers whose recertification is approved immediately will also be able to print a copy of the approval letter and the Provider Agreement signed by the DHS.

In other cases, the final screen will give providers additional instructions to complete recertification, such as the following:

- The recertification application requires review. Providers are mailed the approval letter and other materials when the application is approved.
- Some providers may be required to send additional paper documentation to ForwardHealth.

Sanctions

Intermediate Sanctions

According to DHS 106.08(3), Wis. Admin. Code, the DHS 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.

Involuntary Termination

The DHS may suspend or terminate the Medicaid certification 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 certification 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 certification with Wisconsin Medicaid, termination from Medicare results in automatic termination from Wisconsin Medicaid.

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 certification. 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 49.49(3m), Wis. Stats.

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

Withholding Payments

The DHS 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.

Claims

2

Archive Date:03/01/2011

Claims:Adjustment Requests

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 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.

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.

Electronic

837 Transaction

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

Provider Electronic Solutions Software

The DHCAA offers electronic billing software at no cost to providers. The PES 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 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.

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 Helpdesk for assistance with electronic adjustment requests.

Paper

Paper adjustment requests must be submitted using the Adjustment/Reconsideration Request form.

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.

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.

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.

Submitting Paper Attachments with Electronic Claim Adjustments

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

Good Faith Claims

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 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 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 code, providers should contact Provider Services for assistance.

Overpayments

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.

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 certified on the DOS.
- 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 document for the appropriate 837 transaction when submitting adjustment requests.

Paper Adjustment Requests

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

- Submit an Adjustment/Reconsideration Request 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.

Cash Refunds

When submitting a personal check to ForwardHealth for an overpayment, providers should include a copy of the RA 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, the NPI (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

6406 Bridge Rd
Madison WI 53784-0004

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.

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.

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

An Overview of the Remittance Advice

The RA 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 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 new CSV format.

National Provider Identifier on the Remittance Advice

Providers who have a single NPI that is used for multiple certifications will receive an RA for each certification 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 certified by 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.

Calculating Totals on the Remittance Advice for Adjusted and Paid Claims

The total amounts for all adjusted or paid claims reported on the RA appear at the end of the adjusted claims and paid claims sections in the TXT file. Pay-out amounts are in the Financial Transactions section in the CSV. ForwardHealth calculates the total by adding the amounts for all of the claims; 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 codes and will not display an exact dollar amount.

Claim Number

Each claim or adjustment request received by ForwardHealth is assigned a unique claim number (also known as the ICN). However, denied claims submitted using the NCPDP 5.1 transaction are not assigned an ICN.

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.

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 system or the 276/277 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.

Information is available for DOS before September 1, 2010.

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 codes specific to the ClaimCheck review appear in the TXT RA file and in the electronic 835 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 (Layer of closure of wounds, 12.6 cm to 20.0 cm) and 12036 (Layer closure of wounds, 20.1 cm to 30.0 cm), ClaimCheck rebundles them to procedure code 12037 (Layer closure of wounds 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 services are reported separately when a substantial diagnostic or therapeutic procedure is performed. Under CMS 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 procedure ranges 92002-92019, 99024 (postoperative follow-up), 99026-99058 (special services), 99201-99456 (E&M codes) and HCPCS 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. 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 outpatient visit for the evaluation and management of an established patient) 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 as its primary source for determining assistant surgeon designations. ForwardHealth has updated the list of procedure codes allowable with an assistant surgeon designation to be 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, with supporting documentation and the words, "medical consultant review requested" written on the form, to Provider Services Written Correspondence.

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; the detail line EOB codes inform providers that an amount was deducted from the total reimbursement but may not indicate the exact amount.

Note: Providers who receive 835 transactions will be able to see all deducted amounts on paid and adjusted claims.

Duplicate Claim Denials Within Seven Days

If a pharmacy's drug claim with an NDC is received by ForwardHealth and a subsequent professional claim for the same drug is received from a clinic with the equivalent drug-related HCPCS procedure code, having a DOS 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
6406 Bridge Rd
Madison WI 53784-0005

Electronic Remittance Information

Providers are required to access their secure ForwardHealth provider Portal account to obtain their RAs. 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 format or from a CSV 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 new "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 new "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.

The CSV User Guide includes 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 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 claim submitted by a pharmacy using the NCPDP 5.1 transaction will not appear on remittance information if the claim is denied by ForwardHealth. ForwardHealth releases payment information to the 835 no sooner than on the first state business day following the financial cycle.

Provider Electronic Solutions Software

The DHCAA offers electronic billing software at no cost to the provider. The PES software allows providers to download the 835 transaction. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI Helpdesk.

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

EOB 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 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 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 file.

CSV File

EOB codes are listed in the RA information from the CSV file; however, the printed message corresponding to the codes do not appear in the file. The EOB Code Listing matching standard EOB codes to explanation text are available on the Portal for reference.

Identifying the Claims Reported on the Remittance Advice

The RA reports the first 12 characters of the MRN and/or a PCN, 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.

Obtaining the Remittance Advice

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

Overview of Claims Processing Information on the Remittance Advice

The claims processing sections of the RA 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.

Prior Authorization Number on the Remittance Advice

The RA reports PA numbers used to process the claim. PA numbers appear in the detail lines of claims processing information.

Reading Non-Claims Processing Sections of the Remittance Advice

Address Page

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

Banner Messages

The Banner Messages section of the RA 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 file. Banner messages are posted in the "View Remittance Advices" menu on the provider's secure Portal account.

Explanation of Benefits Code Descriptions

EOB Code Descriptions are listed in the RA information in the TXT file.

EOBs are listed in the RA information from the CSV file; however, the printed message corresponding to the codes does not appear in the file. The EOB listing matches standard EOB codes to explanation text is available on the Portal for reference.

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 under "Accounts Receivable." The "Total Recoupment" field lists the cumulative amount recovered for the accounts receivable.

Every financial transaction that results in the creation of an accounts receivable is assigned an identification number called the "adjustment ICN." The adjustment ICN for an adjusted claim matches the original ICN assigned to the adjusted claim. For other

financial transactions, the adjustment ICN is determined by the following formula.

Type of Character and Description	Applicable Characters and Description
Transaction — The first character indicates the type of financial transaction that created the accounts receivable.	V — Capitation adjustment 1 — OBRA Level 1 screening void request 2 — OBRA Nurse Aide Training/Testing void request
Identifier — 10 additional numbers are assigned to complete the Adjustment ICN.	The identifier is used internally by ForwardHealth.

Service Code Descriptions

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

Summary

The Summary section reviews the provider's claim activity and financial transactions with the payer (Medicaid, WCDP, or WWWP) 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 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.

Reading the Claim Adjustments Section of the Remittance Advice

Providers receive a Claim Adjustments section in the RA 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.

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

The claim adjustments section lists detail lines only for the adjusted claim with detail line EOBs. Details from the original claim will not be reported on the adjusted claims sections of the RA.

Note: For adjusted drug 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."

An amount appears for "additional payment" if ForwardHealth owes additional monies to the provider after the claim has been adjusted. This amount will be added to the provider's total reimbursable amount for the RA.

An amount appears for "overpayment to be withheld" if ForwardHealth determines, as the result of an adjustment to the original claim, that the provider owes ForwardHealth monies. 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.

Reading the Claims Denied Section of the Remittance Advice

Providers receive a Claims Denied section in the RA 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 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.

Reading the Claims Paid Section of the Remittance Advice

Providers receive a Claims Paid section in the RA 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 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.

Remittance Advice Financial Cycles

Each financial payer (Medicaid, WCDP, and WWWP) has separate financial cycles that occur on different days of the week. RAs are generated and posted to secure provider Portal accounts after each financial cycle is completed. Therefore, RAs may be generated and posted to secure provider Portal accounts from different payers on different days of the week.

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

Remittance Advice Generated by Payer and by Provider

Certification

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

- Wisconsin Medicaid (Wisconsin Medicaid is the financial payer for the Medicaid, BadgerCare Plus, and SeniorCare programs).
- WCDP.
- WWWP.

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 certification. Providers who have a single NPI that is used for multiple certifications should be aware that an RA will be generated for each certification, 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 certified 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.

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 and ForwardHealth-issued 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.)
- 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
6406 Bridge Rd
Madison WI 53784-0005

Searching for and Viewing All Claims on the Portal

All claims, including pharmacy 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 ForwardHealth 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.

Sections of the Remittance Advice

The RA information in the TXT file includes the following sections:

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

The RA information in the CSV file includes the following sections:

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

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

Remittance Advice Header Information

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

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

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

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

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.

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.

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.
- 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.
- 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.

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. 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).

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, BadgerCare Plus automatically deducts the copayment amount.

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

Submission

1500 Health Insurance Claim Form Completion Instructions for Clozapine Management Services

A sample 1500 Health Insurance Claim Form is available for clozapine management 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. 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
6406 Bridge Rd
Madison WI 53784-0002

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 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 MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/CCYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the member is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name
Data are required in this element for OCR 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 or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the member has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), Vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial health insurance, and the service requires other insurance billing, one of the following three OI explanation codes must be indicated in the first box of Element 9. If submitting a multiple-page claim, providers are required to indicate OI explanation codes on the *first page* of the claim.

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

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

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

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

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

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

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

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

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

Element 11 — Insured's Policy Group or FECA Number (not required)

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

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

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

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

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

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

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

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

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

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

Element 17a (not required)

Element 17b — NPI (not required)

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

Element 19 — Reserved for Local Use (not required)

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

Element 21 — Diagnosis or Nature of Illness or Injury
Enter a valid ICD-9-CM diagnosis code (295.10-295.95) for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

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

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

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

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

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

Element 24A — Date(s) of Service
Enter to and from DOS in MM/DD/YY or MM/DD/CCYY 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 MM/DD/YY or MM/DD/CCYY format.

A range of dates may be indicated only if the POS, the procedure code (and modifiers, if applicable), the charge, and the units 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 (not required)

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

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

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

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

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

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

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

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

Element 24I — ID Qual (not required)

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

Element 25 — Federal Tax ID Number (not required)

Element 26 — Patient's Account No. (not required)
Optional — Providers may enter up to 14 characters of the patient's internal office account number. This number will appear on the RA and/or the 835 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 MM/DD/YY or MM/DD/CCYY 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.

Element 33a — NPI

Enter the NPI of the billing provider.

Element 33b

Enter qualifier "ZZ" followed by the 10-digit provider taxonomy code.

Do not include a space between the qualifier ("ZZ") and the provider taxonomy code.

1500 Health Insurance Claim Form Completion Instructions for Physician Services

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

- 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. 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
6406 Bridge Rd
Madison WI 53784-0002

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 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 MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/CCYY format (e.g., February 3, 1955, would be 02/03/1955). 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 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 or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the member has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), Vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial health insurance, and the service requires other insurance billing, one of the following three OI explanation codes must be indicated in the first box of Element 9. If submitting a multiple-page claim, providers are required to indicate OI explanation codes on the *first page* of the claim.

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

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

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

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

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

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

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

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

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

Element 11 — Insured's Policy Group or FECA Number
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 Medicare Cost ("MCC") or Medicare + Choice ("MPC") 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 Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

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

Code	Description
M-7	Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. *For Medicare Part A, use M-7 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as certified for Medicare Part A. • The member is eligible for Medicare Part A. • The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or exhausted benefits. *For Medicare Part B, use M-7 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as certified for Medicare Part B. • The member is eligible for Medicare Part B. • The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or exhausted benefits.
M-8	Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. *For Medicare Part A, use M-8 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as certified for 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 certified for 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 (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 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 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)
NDCs must be indicated in the shaded area of Elements 24A-24G. Providers may indicate up to two NDCs per completed service line. 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], ML [Milliliter], or UN [Unit]), followed by the NDC units, with no space in between. The NDC units should be recorded with an implied decimal three digits from the left; for example, to indicate a unit of "1," "1000" would be entered after the unit qualifier.
- If indicating two NDCs in a service line, separate the two "sets" of NDC data by three spaces.
- When submitting more than one NDC on a claim, providers are required to use HCPCS service code J3490.

For example, two NDCs indicated in the shaded area of Elements 24A-24G would look like:
N412345678912 GR123678 N498765432198 UN67000

Element 24A — Date(s) of Service
Enter to and from DOS in MM/DD/YY or MM/DD/CCYY 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 MM/DD/YY or MM/DD/CCYY format.

A range of dates may be indicated only if the POS, 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 than 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 than 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 and/or the 835 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 MM/DD/YY or MM/DD/CCYY 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.

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

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

Advanced Imaging Services

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

Submitting Claims for Situations Exempt from the Prior Authorization Requirement

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

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

Service Provided During an Inpatient Stay

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

Institutional claims for advanced imaging services provided during a member's inpatient hospital stay are automatically exempt from PA requirements. Providers submitting a professional claim for advanced imaging services provided during a member's inpatient hospital stay should indicate POS 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/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 should refer to the appropriate companion document 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 document 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 document for instructions on including a modifier.

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

Attached Documentation

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

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

- An Abortion Certification Statements 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.
- Surgeries performed by cosurgeons.

Claims Submission

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 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 may be indicated on the claim. Providers may submit claims for clozapine management only as often as a member's WBC count and ANC 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 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 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

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 along with the claim status.

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

Providers can view EOB 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.

Direct Data Entry of Professional and Institutional Claims on the Portal

Providers can submit the following claims to ForwardHealth via DDE 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.
- POS codes.

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

- Type of bill.
- Patient status.
- Admission source.
- Admission type.
- 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.
- POS.

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

- Diagnosis codes.
- NDCs.
- Patient location 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 or of DMS who submits noncompound drug claims, may submit these claims via DDE. All claims, including POS claims, are viewable via DDE.

Electronic Claims Submission

Providers are encouraged to submit claims electronically. Electronic claims 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.

Electronic Claims Submission for Physician Services

Electronic claims for physician services must be submitted using the 837P transaction. Electronic claims for physician services submitted using any transaction other than the 837P will be denied.

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

Provider Electronic Solutions Software

The DHCAA offers electronic billing software at no cost to providers. The PES 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 Helpdesk.

Extraordinary Claims

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

HIPAA-Compliant Data Requirements

Procedure Codes

All fields submitted on paper and electronic claims are edited to ensure HIPAA compliance before being processed. Compliant code sets include CPT and HCPCS 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 are required in all provider number fields on paper claims and 837 transactions, including rendering, billing, referring, prescribing, attending, and "Other" provider fields.

Non-healthcare providers, including personal care providers, SMV providers, blood banks, and CCOs should enter valid provider numbers into fields that require a provider number.

Managed Care Organizations

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

Noncertified Providers

Claims from noncertified in-state providers must meet additional requirements.

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, 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 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 and PES software when providers submit the following types of claims:

- Institutional.
- Professional.
- Dental.

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

Claims Submitted Via the 837 Health Care Claim Transaction

ForwardHealth accepts and utilizes information submitted by providers about NOC procedure codes in the following loop/segments on the 837 transactions:

- Loop 2300, segment NTE for 837 Health Care Claim: Institutional.
- Loop 2400, segment NTE for 837 Health Care Claim: Professional.
- Loop 2400, segment NTE for 837 Health Care Claim: Dental.

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 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 and the Noncompound Drug Claim.

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.

Paper Claim Submission

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.

Prior Authorization Numbers on Claims

Providers are not required to indicate a PA number on claims. ForwardHealth interChange matches the claim with the appropriate approved PA request. ForwardHealth's RA and the 835 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.

Provider-Administered Drugs

Deficit Reduction Act of 2005

Providers are required to comply with requirements of the federal DRA of 2005 and submit NDCs with HCPCS procedure codes on claims for provider-administered drugs. Section 1927(a)(7)(B) of the Social Security Act requires NDCs to be indicated on all claims submitted to ForwardHealth, 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 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 for provider-administered drugs. NDCs must be indicated on claims where Medicare is the primary payer. Medicare claims with an NDC present should automatically cross over to ForwardHealth.

ForwardHealth will deny crossover claims if an NDC was not submitted to Medicare.

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 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 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 EOB code 1309 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 form along with the Pharmacy Special Handling Request form indicating the EOB code and requesting an override.

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

For Dates of Service On and After January 1, 2009

For DOS on and after January 1, 2009, for members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, BadgerCare Plus and Medicaid fee-for-service, not the member's MCO, 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 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) for DOS prior to January 1, 2009, 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 DRA information page.
- NUBC.
- NUCC.

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

- The FDA Web site.
- The Drug Search Tool. (Providers may verify if an NDC and its segments are valid using this Web site.)
- The Noridian Administrative Services NDC to HCPCS crosswalk.

Claims from Prescribers

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

- A 1500 Health Insurance Claim Form.
- The 837P transaction.
- The DDE on ForwardHealth Portal.
- The PES software.

1500 Health Insurance Claim Form

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], ML [Milliliter], or UN [Unit]), followed by the NDC units, with no space in between.

N412345678901 UN1234.567 is an example of what may be indicated in Elements 24A-24G of the 1500 Health Insurance Claim Form.

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 Helpdesk.

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 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 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 Form.
- Noncompound Drug Claim Form.

Exceptions to Paper Claim Reimbursement Reduction

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

- In-state emergency providers.
- Out-of-state providers.
- Medicare Crossover Claims.
- Any claims that ForwardHealth requires additional supporting information to be submitted on paper. For example:
    - Hysterectomy claims must be submitted along with a paper Acknowledgement of Receipt of Hysterectomy Information Form.
    - Sterilization claims must be submitted along with a paper Consent for Sterilization Form.
    - Claims submitted to Timely Filing appeals must be submitted on paper with a Timely Filing Appeals Request form.
    - In certain circumstances, drug claims must be submitted on paper with a Pharmacy Special Handling Request.

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, 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.

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 documents 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. Providers are required to indicate an ACN 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
6406 Bridge Rd
Madison WI 53784-0002

This does not apply to pharmacy claims.

Synagis

Synagis® (palivizumab), a monoclonal antibody, is used to prevent lower respiratory tract diseases caused by RSV 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 is required for Synagis®.

Synagis® is not part of the provider-administered drugs carve-out policy; therefore, a member's MCO should reimburse providers for Synagis®.

Professional Claim Submission

Information is available for DOS before October 15, 2009.

Claims for Synagis® must be submitted using the 837P transaction or on the 1500 Health Insurance Claim Form. Prescribers and pharmacy providers are required to indicate CPT procedure code 90378 (Respiratory syncytial virus immune globulin [RSV-IgIM], for intramuscular use, 50 mg, each) and the appropriate unit(s) on each claim submission. To comply with the requirements of the DRA, the NDC 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 Synagis®, one unit equals 50 mg. The dose should be indicated on claims as the number of 50 mg vials administered. Providers should obtain the dose from the appropriately sized vial of Synagis® and indicate the corresponding NDC on claims. For example, a 155 mg calculated dose is equal to four units of Synagis®.

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.

Unlisted Procedure Codes

According to the HCPCS code book, if a service is provided that is not accurately described by other HCPCS/CPT procedure codes, the service should be reported using an unlisted procedure code.

Before considering using an unlisted, or NOC, 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 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 Direct Data Entry through the ForwardHealth Portal, PES 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.

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 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 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

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 form with a paper claim or an Adjustment/Reconsideration Request form to override the submission deadline.

DOS 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.

Resubmission

Decisions on Timely Filing Appeals Requests 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.

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 form.
- 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 code, etc., as effective for the DOS. 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 form. The most recent claim number (also known as the ICN) must be indicated on the Adjustment/Reconsideration	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

	Request form. This number may be the result of a ForwardHealth-initiated adjustment.	

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.	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 6406 Bridge Rd Madison WI 53784-0050

Denial Due to Discrepancy Between the Member's Enrollment Information in ForwardHealth interChange and the Member's Actual Enrollment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a claim is initially received by the deadline but is denied due to a discrepancy between the member's enrollment information in ForwardHealth interChange and the member's actual enrollment.	To receive consideration, the following documentation must be submitted within 455 days from the DOS: • A copy of remittance information showing the claim was submitted in a timely manner and denied with a qualifying enrollment-related explanation. • A photocopy of one of the following indicating enrollment on the DOS: ◦ White paper BadgerCare Plus EE for pregnant women or children identification card. ◦ Green paper temporary identification card. ◦ White paper TE for Family Planning Only Services identification card. ◦ The response received through the EVS from a commercial eligibility vendor. ◦ The transaction log number received through WiCall.	ForwardHealth Good Faith/Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

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 message. A copy of the RA message that shows the ForwardHealth-initiated adjustment must be submitted with the request.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Retroactive Enrollment for Persons on General Relief		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when the local	To receive consideration, the request must be submitted	ForwardHealth

county or tribal agency requests a return of a GR payment from the provider because a member has become retroactively enrolled for Wisconsin Medicaid or BadgerCare Plus.	within 180 days from the date the backdated enrollment was added to the member's enrollment information. The request must be submitted with one of the following: • "GR retroactive enrollment" indicated on the claim. • A copy of the letter received from the local county or tribal agency.	GR Retro Eligibility Ste 50 6406 Bridge Rd Madison WI 53784-0050

Medicare Denial Occurs After the Submission Deadline		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when claims submitted to Medicare (within 365 days of the DOS) are denied by Medicare after the 365-day submission deadline. A waiver of the submission deadline will not be granted when Medicare denies a claim for one of the following reasons: • The charges were previously submitted to Medicare. • The member name and identification number do not match. • The services were previously denied by Medicare. • The provider retroactively applied for Medicare enrollment and did not become enrolled.	To receive consideration, the following must be submitted within 90 days of the Medicare processing date: • A copy of the Medicare remittance information. • The appropriate Medicare disclaimer code must be indicated on the claim.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Refund Request from an Other Health Insurance Source		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when an other health insurance source reviews a previously paid claim and determines that reimbursement was inappropriate.	To receive consideration, the following documentation must be submitted within 90 days from the date of recoupment notification: • A copy of the commercial health insurance remittance information. • A copy of the remittance information showing recoupment for crossover claims when Medicare is recouping payment.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

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 6406 Bridge Rd Madison WI 53784-0050

Coordination of Benefits

3

Archive Date:03/01/2011

Coordination of Benefits:Commercial Health Insurance

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.

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

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.

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 (i.e., state-contracted MCO, 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 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.

Definition of Commercial Health Insurance

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

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.

Exhausting Commercial Health Insurance Sources

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

Step 1. Determine if the Member Has Commercial Health Insurance
If Wisconsin's EVS does not indicate that the member has commercial health insurance, the provider may submit a claim to ForwardHealth unless the provider is otherwise aware of commercial health insurance coverage. **If the member disputes the information as it is indicated in the EVS,** the provider should submit a completed Other Coverage Discrepancy Report form. Unless the service does not require other health insurance billing, the provider should allow at least two weeks before proceeding to Step 2.
Step 2. Determine if the Service Requires Other Health Insurance Billing
If the service requires other health insurance billing, the provider should proceed to Step 3. **If the service does not require other health insurance billing,** the provider should proceed in one of the following ways: • The provider is encouraged to bill commercial health insurance if he or she believes that benefits are available. Reimbursement from commercial health insurance may be greater than the BadgerCare Plus-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 BadgerCare Plus and commercial health insurance simultaneously. Simultaneous billing may constitute fraud and interferes with BadgerCare Plus'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 BadgerCare Plus and the member, the provider is required to return the lesser amount to BadgerCare Plus.

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.

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, BadgerCare Plus will pay for services covered by both BadgerCare Plus 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 Provider Electronic Solutions Manual or the appropriate 837 companion document to determine the appropriate other insurance indicator for electronic claims.

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.

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 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 indicates no commercial health insurance for the DOS.
- The service does not require other health insurance billing.
- Claim denials from other payers relating to NPI 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.

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.
- CRS.
- Family planning services.
- PNCC services.
- Preventive pediatric services.
- SMV services.

Services Requiring Commercial Health Insurance Billing

If the EVS indicates the code **"DEN"** for "Other Coverage," the provider is required to bill dental services to commercial health insurance before submitting claims to ForwardHealth.

If the EVS indicates that the member has Wausau Health Protection Plan (**"HPP"**), BlueCross & BlueShield (**"BLU"**), Wisconsin Physicians Service (**"WPS"**), TriCare (**"CHA"**), or some other (**"OTH"**) 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.
- Blood bank services.

- Chiropractic services.
- CSP services.
- Dental services.
- DME (rental or purchase), prosthetics, and hearing aids if the billed amount is over $10.00 per item.
- Home health services (excluding PC 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.
- PT, OT, and SLP 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 services for ventilator-dependent members.
- Radiology services.
- RHC services.
- Skilled nursing home care, if any DOS 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 the EVS indicates the code **"VIS"** for "Other Coverage", the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- Ophthalmology services.
- Optometrist services.

If the EVS indicates the code **"HMO"** for "Other Coverage," 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.
- Blood bank services.
- Chiropractic services.
- CSP services.
- Dental services.
- DME (rental or purchase), prosthetics, and hearing aids if the billed amount is over $10.00 per item.
- Home health services (excluding PC services).
- Hospice services.
- Hospital services, including inpatient or outpatient regardless of the type of hospital.
- Independent nurse, nurse practitioner, or nurse midwife services.
- Laboratory services.
- Medicare-covered services billed for a member who has both Medicare and commercial health insurance.
- Mental health/substance abuse services, including services delivered by providers other than physicians, regardless of POS.
- Pharmacy services for members with verified drug coverage.
- PT, OT, and SLP services, unless provided in a nursing home or SNF.
- Physician and physician assistant services.
- Podiatry services.
- PDN services for ventilator-dependent members.

- Radiology services.
- RHC services.
- Skilled nursing home care, if any DOS 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 the EVS indicates Medicare Supplemental Plan Coverage (**"SUP"**), 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 service 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.

BadgerCare Plus has identified services requiring Medicare billing.

Medicare

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 member is required to accept assignment of the member's Medicare Part B benefits. Therefore, total payment for the 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.

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.

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.

Claims That Do Not Require Medicare Billing

For services provided to dual eligibles, 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.

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. Claims with an NPI 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 designated by ForwardHealth is required to identify the billing provider and 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 designated by ForwardHealth and the ZIP+4 code of the practice location on file with ForwardHealth are required when additional data is needed to identify the provider.

Claims for Services Denied by Medicare

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

Crossover Claims

A Medicare crossover claim is a Medicare-allowed claim for a dual eligible or QMB-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 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.

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 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 at the time the service was submitted to Medicare for payment, but the member was retroactively determined enrolled in BadgerCare Plus.
- 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 that ForwardHealth has on file for the provider.
- Taxonomy code that is required by ForwardHealth.
- 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 through the ForwardHealth Provider Portal.
- 837I transaction, as applicable.
- 837P transaction, as applicable.
- PES software.
- Paper claim form.

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

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-covered services, even those that are not allowed by Medicare.

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 form, the provider should attach a copy of Medicare remittance information. (If this is a Medicare reconsideration, copies of the original and subsequent Medicare remittance information should be attached.)

Provider-Submitted Crossover Claim

The provider may submit a provider-submitted crossover claim in the following situations:
 	
• The claim is for a member who is enrolled in a Medicare Advantage Plan.
• The automatic crossover claim is not processed by ForwardHealth within 30 days of the Medicare processing date.
• ForwardHealth denied the automatic crossover claim and additional information may allow payment.
• The claim is for a member who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (e.g., Medicare Supplemental).
• The claim is for a member who was not enrolled in BadgerCare Plus at the time the service was submitted to Medicare for payment, but the member was retroactively enrolled.*
 	
When submitting provider-submitted crossover claims, the provider is required to follow all claims submission requirements in addition to the following:
 	
• For electronic claims, indicate the Medicare payment.
• For paper claims, the provider is required to the do the following:
  ○ Attach Medicare's remittance information and refrain from indicating the Medicare payment.
  ○ Indicate "MMC" 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 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, the provider may proceed as follows: • Bill commercial health insurance, if applicable. • Submit a claim to ForwardHealth using the appropriate Medicare disclaimer code. If applicable, the provider should indicate the appropriate other insurance indicator. A copy of Medicare remittance information should not be attached to the claim.

Crossover Claim Previously Reimbursed
A crossover claim may have been previously reimbursed by Wisconsin Medicaid when one of the following has occured:

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

In these situations, the provider should proceed as follows:

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

Medicare Advantage

Medicare services may be provided to dual eligibles or QMB-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 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. This is necessary in order for ForwardHealth to distinguish whether the claim has been processed as commercial managed care or Medicare managed care.

Crossover claims for Medicare Part B covered drugs for members enrolled in the Standard Plan, Medicaid, or SeniorCare with a Medicare Advantage plan will deny due to the Medicare Advantage plan being on the member's file. To be reimbursed, providers are required to submit a Pharmacy Special Handling Request and a Noncompound Drug Claim. Providers should indicate the member is enrolled in a Medicare Advantage plan and indicate the Medicare Part B covered drug on the Pharmacy Special Handling Request.

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.

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 Wisconsin Medicaid constitutes fraud.

Medicare disclaimer codes identify the status and availability of Medicare benefits. The code allows a provider to be reimbursed correctly by Wisconsin Medicaid 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.

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(6) and 106.03(7)(b), 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 B 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 certified provider who is enrolled in Medicare.

To receive Medicaid reimbursement for a Medicare Part B service provided to a dual eligible, a provider who is not enrolled in Medicare but can be is required to apply for retroactive enrollment.

Services for Qualified Medicare Beneficiary-Only Members

Because QMB-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 certified provider who is enrolled in Medicare.

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 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 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 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.

Medicare Retroactive Eligibility

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

Modifier for Catastrophe/Disaster-Related Crossover Claims

ForwardHealth accepts modifier "CR" (Catastrophe/disaster related) on Medicare crossover claims (both 837P transactions and 1500 Health Care Claim Forms) to accommodate the emergency health care needs of dual eligibles and QMB-Only members affected by disasters. The CMS Web site contains more information.

National Provider Identifier and Related Data on Crossover Claims

An NPI and related data are required on crossover claims, in most instances. However, in some cases the taxonomy code designated by ForwardHealth may not be indicated on automatic crossover claims received from Medicare.

Secondary NPI

Medicare requires that certain subparts of an organization obtain separate NPIs and use the NPI for billing Medicare (e.g., hospital psychiatric unit). If an organization has identified subparts for the purpose of submitting claims to Medicare, and the NPIs appear on automatic crossover claims to ForwardHealth, ForwardHealth considers the NPIs submitted to Medicare to be secondary NPIs. ForwardHealth will process automatic crossover claims using secondary NPIs in cases where the provider has reported a secondary NPI to ForwardHealth. Along with the NPI, providers should also indicate the taxonomy and ZIP+4 code information.

Taxonomy Code Designated by ForwardHealth

The taxonomy code indicated on automatic crossover claims received from Medicare may be different than the taxonomy designated by ForwardHealth. Providers should resubmit the claim to ForwardHealth when the taxonomy code designated by ForwardHealth is required to identify the provider and is not indicated on the crossover claim received from Medicare.

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 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.

Qualified Medicare Beneficiary-Only Members

QMB-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.

Reimbursement for Crossover Claims

Professional Crossover Claims

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

Total payment for a Medicare Part B 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 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 examples of how the limitations are applied.

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

Outpatient Hospital Crossover Claims

Detail-level information is used to calculate pricing for all outpatient hospital crossover claims and adjustments. Details that Medicare paid in full or that Medicare denied in full will not be considered when pricing outpatient hospital crossover claims. Medicare deductibles are paid in full.

Providers may use the following steps to determine how reimbursement was calculated:

1. Sum all of the detail Medicare paid amounts to establish the Claim Medicare paid amount.
2. Sum all of the detail Medicare coinsurance or copayment amounts to establish the Claim Medicare coinsurance or copayment amount.
3. Multiply the number of DOS by the provider's rate-per-visit. For example, $100 (rate-per-visit) x 3 (DOS) = $300. This is the Medicaid gross allowed amount.
4. Compare the Medicaid gross allowed amount calculated in step 3 to the Claim Medicare paid amount calculated in step 1. If the Medicaid gross allowed amount is less than or equal to the Medicare paid amount, Wisconsin Medicaid will make no further payment to the provider for the claim. If the Medicaid gross allowed amount is greater than the Medicare paid amount, the difference establishes the Medicaid net allowed amount.
5. Compare the Medicaid net allowed amount calculated in step 4 and the Medicare coinsurance or copayment amount calculated in step 2. Wisconsin Medicaid reimburses the lower of the two amounts.

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 transaction when a taxonomy code is reported in both the Billing/Pay-to Provider Loop (2000A) and in the Rendering Provider Loop (2310B) 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 certifications. Providers should refer to the 837 companion documents for information on using taxonomy codes on standard claims transactions. ForwardHealth will accept the 837P transaction when a taxonomy code is reported in both the Billing/Pay-to Provider Loop (2000A) and in the Rendering Provider Loop (2310B) and the billing and rendering providers are different.

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

acknowledged that health plans may need the billing provider taxonomy in order to accurately process claims.

Services Requiring Medicare Billing

If the EVS indicates Medicare + Choice (**"MPC"**) for "Medicare Managed Care Coverage," the provider is required to bill the following services to the Medicare Advantage Plan before submitting claims to ForwardHealth:

- Ambulance services.
- Ambulatory service center 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.

If the EVS indicates Medicare Cost (**"MCC"**) for "Medicare Managed Care Coverage," 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

After Reporting Discrepancies

After receiving an Other Coverage Discrepancy Report, 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 that the member's other coverage information has been updated.
- The provider receives a written explanation.

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.

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.

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 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.

Reporting Discrepancies

Providers are encouraged to report discrepancies to ForwardHealth by submitting the Other Coverage Discrepancy Report 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.

- 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.

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

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

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.

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.

Responding to ForwardHealth After 120 Days

If a response is not received within 120 days, the amount originally paid by BadgerCare Plus 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 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 that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.	A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim).	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The provider discovers that the member's	• An Other Coverage Discrepancy Report form.	Send the Other Coverage

other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	• A claim according to normal claims submission procedures after verifying that the member's other coverage information has been updated by using the EVS (do *not* use the prepared provider-based billing claim).	Discrepancy Report form to the address indicated on the form. Send the claim to the following address: ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator. • The amount received from the other health insurance source.	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The other health insurance source denies the provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator or Medicare disclaimer code.	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The commercial health insurance carrier does not respond to an initial *and* follow-up provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator.	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002

Beyond Claims Submission Deadlines		
Scenario	**Documentation Requirement**	**Submission Address**
The provider discovers through the EVS that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.	• A claim (do *not* use the prepared provider-based billing claim). • A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050
The provider discovers that the member's other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	• An Other Coverage Discrepancy Report form. • *After* using the EVS to verify that the member's other coverage information has been updated, include both of the following: ◦ A claim (do *not* use the prepared provider-based billing claim.) ◦ A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	Send the Other Coverage Discrepancy Report form to the address indicated on the form. Send the timely filing appeals request to the following address: ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050
The commercial health insurance carrier reimburses or partially	• A claim (do *not* use the prepared provider-based billing claim).	ForwardHealth Timely Filing

reimburses the 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.	Ste 50 6406 Bridge Rd Madison WI 53784-0050
The other health insurance source denies the provider-based billing claim.	• A claim (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator or Medicare disclaimer code. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures. • The Provider-Based Billing Summary. • Documentation of the denial, including any of the following: ◦ Remittance information from the other health insurance source. ◦ A written statement from the other health insurance source identifying the reason for denial. ◦ A letter from the other health insurance source indicating a policy termination date that proves that the other health insurance source paid the member. ◦ A copy of the insurance card or other documentation from the other health insurance source that indicates that the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage only. • The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050
The commercial health insurance carrier does not respond to an initial and follow-up provider-based billing claim.	• A claim (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

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 that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.
- The provider verifies that the member's other coverage information reported by ForwardHealth is invalid.
- The other health insurance source reimbursed or partially reimbursed the provider-based billing claim.
- The other health insurance source denied the provider-based billing claim.

- The other health insurance source failed to respond to an initial *and* follow-up provider-based billing claim.

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

Scenario	Documentation Requirement	Submission Address
The provider discovers through the EVS that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.	• The Provider-Based Billing Summary. • Indication that the EVS no longer reports the member's other coverage.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The provider discovers that the member's other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	• The Provider-Based Billing Summary. • One of the following: ◦ The name of the person with whom the provider spoke and the member's correct other coverage information. ◦ A printed page from an enrollment Web site containing the member's correct other coverage information.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	• The Provider-Based Billing Summary. • A copy of the remittance information received from the other health insurance source. • The DOS, other health insurance source, billed amount, and procedure code indicated on the other insurer's remittance information must match the information on the Provider-Based Billing Summary. *Note:* In this situation, ForwardHealth will initiate an adjustment if the amount of the other health insurance payment does not exceed the allowed amount (even though an adjustment request should not be submitted). However, providers (except nursing home and hospital providers) may issue a cash refund. Providers who choose this option should include a refund check but should not use the Claim Refund form.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The other health insurance source denies the provider-based billing claim.	• The Provider-Based Billing Summary. • Documentation of the denial, including any of the following: ◦ Remittance information from the other health insurance source. ◦ A letter from the other health insurance source indicating a policy termination date that precedes the DOS. ◦ Documentation indicating that the other health insurance source paid the member. ◦ A copy of the insurance card or other documentation from the other health insurance source that indicates the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage. • The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The other health insurance	• The Provider-Based Billing Summary.	ForwardHealth

source fails to respond to the initial *and* follow-up provider-based billing claim.	• 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.	Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567

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

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

The provider may choose a different option for each DOS. 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.

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, 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.

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.

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

4

Archive Date:03/01/2011

Covered and Noncovered Services:Clozapine Management

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.

Clozapine Coverage for Dual Eligibles

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

Clozapine Management

Clozapine management is a specialized care management service that may be required to ensure the safety of members who are receiving this psychoactive medication.

Wisconsin Medicaid and SeniorCare reimburse clozapine separately for outpatient and nursing home residents. Clozapine management is reimbursable only for outpatient services.

Conditions for Coverage

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 following components of clozapine management.

Clozapine is appropriate for members with a diagnosis of a schizophrenic disorder (ICD-9-CM 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.

Components of Clozapine Management

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 weekly or biweekly WBC count testing. Members must have a blood sample drawn for WBC count testing before initiation of treatment with clozapine and must have subsequent WBC counts done weekly for the first six months of clozapine therapy. (BadgerCare Plus and Wisconsin SeniorCare cover WBC count services separately from clozapine management. A WBC count must be performed and a claims submitted by a Medicaid-certified provider to be reimbursed by Wisconsin Medicaid.)

  If a member has been on clozapine therapy for six months of continuous treatment and if the weekly WBC counts remain stable (greater than or equal to 3,000/mm^3) during the period, the frequency of WBC count monitoring may be reduced to once every two weeks. For these members, further weekly WBC counts require justification of medical necessity. *Members who have their clozapine dispensed every week but who have a blood draw for WBC count every two weeks qualify for biweekly, not weekly, clozapine management services.*

  For members who have a break in therapy, WBC 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-certified 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 recipient 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 record keeping requirements for clozapine management.

Record Keeping Requirements

The provider who bills 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 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 member 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 counts.
- 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 WBC count.

Pharmacies that provide clozapine management services must be extremely careful not to double bill BadgerCare Plus or Wisconsin SeniorCare for services. This may happen when the physician provides clozapine management services during the same encounter as when they provide other allowable physician services. In these cases, the physician must document the amount of time that was 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.

Noncovered Clozapine Management Services

BadgerCare Plus and Wisconsin SeniorCare do not cover 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.
- Care coordination or medical services not related to the members use of clozapine.

Related Services That Are Reimbursed Separately from Clozapine Management

- *WBC* — The WBC count must be performed and billed by a Medicaid-certified laboratory to receive Medicaid reimbursement.
- *Member Transportation* — Member transportation to a physician's office is reimbursed in accordance with DHS 107.23, Wis. Admin. Code. When provided by a SMV, such transportation is not covered unless the member is certified for SMV services. Member transportation by common carrier must be approved and paid for by the county agency responsible for BadgerCare Plus or SeniorCare transportation services.

Claims Submission

BadgerCare Plus and Wisconsin SeniorCare 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 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 may be indicated on the claim. Providers may submit claims for clozapine management only as often as a member's WBC count and ANC 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 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

The following table lists the allowable POS codes that providers of clozapine management services are required to use when submitting claims.

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	Public Health Clinic
99	Other Place of Service

Blood Count Testing May Be Every Four Weeks if Requirements Are Met

Providers may order WBC count and ANC testing every four weeks for members who have received clozapine management services for a full year with stable and medically appropriate WBC counts and ANCs. BadgerCare Plus and Wisconsin SeniorCare cover clozapine management services at the same frequency as the member's blood count testing. If a prescriber deems more frequent WBC count and ANC testing to be medically necessary *and* orders it, BadgerCare Plus and Wisconsin SeniorCare will cover clozapine management at the higher frequency.

Baseline Blood Count and Frequency Requirements

A member must have a baseline WBC count and ANC before initiation of clozapine management, 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/mm^3 during that period.
- The weekly ANC has remained stable at greater than or equal to 2,000/mm^3 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), the member's WBC count and ANC may be testing every four weeks.

Clozapine Coverage for Dual Eligibles

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

The following are not reimbursable 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.
- Care coordination or medical services not related to the member's use of clozapine.

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 count and ANC testing. According to FDA 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/mm^3 during that period.
  - The weekly ANC has remained stable at greater than or equal to 2,000/mm^3 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-certified 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 recipient'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.

Conditions for Coverage

Physicians and physician clinics 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 count and ANC testing to be medically necessary *and* orders it, BadgerCare Plus will cover clozapine management at the higher frequency.

Member Diagnosis

Clozapine is appropriate for members with an ICD-9-CM 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.

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 recipient 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 counts and ANC 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 recipient received medically necessary care following an abnormal blood test results.

Physicians and physician clinics 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.

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 recipients residing in a nursing facility or hospital on the DOS.
- Care coordination or medical services not related to the member's use of clozapine.

Separately Reimbursable Services

Blood Testing

The WBC count and ANC testing must be performed and billed by a Medicaid-certified 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. When provided by a SMV, such transportation is not covered unless the member is certified for SMV services. Member transportation by common carrier must be approved and paid for by the county agency responsible for Medicaid transportation services.

Codes

Administration Procedure Codes for Provider-Administered Drugs

For provider-administered drugs administered to members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special MCOs, the CPT 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

Age- and Gender-Restricted Contraceptive HCPCS Procedure Codes

HCPCS procedure codes and descriptions for age- and gender-restricted contraceptives are in the table below.

Age- and Gender-Restricted Contraceptives	
Procedure Code	**Description**
J1055	Injection, medroxyprogesterone acetate for contraceptive use, 150 mg
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

Cochlear Implants

Providers should indicate the following procedure codes on PA 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 maximum allowable fee 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, 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

Physicians Required to Obtain Separate Certification

To be reimbursed for dispensing DME, physicians are required to obtain separate Medicaid certification as a medical equipment vendor.

Diagnosis Codes

All diagnosis codes indicated on claims (and PA requests when applicable) must be the most specific ICD-9-CM 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.

Modifiers

Allowable modifiers for physician E&M, 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.
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 or CPT 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	This modifier can be used to indicate separately identifiable procedures on the same DOS. 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. 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.
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	Use of modifier "80" is allowed for those surgery procedures recognized as accepted medical practice. 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.
81	Minimum Assistant Surgeon	Minimum surgical assistant services are identified by adding modifier "81" to the usual procedure number. 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.
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). 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.
AQ	Physician providing service in a HPSA	Providers receive enhanced reimbursement when services are performed in a HPSA.
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.
TH	Obstetrical treatment/ services, prenatal or postpartum	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. 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 recipients 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.

Place of Service Codes

Allowable POS codes for physician E&M, 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

Procedure Codes

Covered E&M, medicine, and surgery services are identified by CPT or HCPCS 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). 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.

Covered Services and Requirements

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 the legal scope of practice.

Alpha Hydroxprogesterone (17P) Caproate Compound Injection

The 17P caproate compound injection is covered for members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, and Medicaid. The compound is available through and only reimbursable for sterile compounding pharmacies.

The 17P compound must be injected by a medical professional. Members may not self-administer the 17P injection.

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

- The pregnancy must be 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 administered beginning at 16 weeks gestation through 37 weeks gestation or delivery, whichever is first.

Claim Submission

Information is available for DOS before May 31, 2010.

Claims for the17P injection must be submitted on paper on the 1500 Health Insurance Claim Form with the new Attestation to Administer Alpha Hydroxyprogesterone (17P) Caproate Injections as an attachment to the claim. Claims for the 17P injection can only be submitted on paper.

On the Attestation to Administer Alpha Hydroxyprogesterone (17P) Caproate Injections, providers are required to sign and date that they have communicated to the member the criteria for coverage of the 17P injection and that the drug is not an FDA-approved drug. Providers should keep a copy of the signed and completed Attestation to Administer Alpha Hydroxyprogesterone (17P) Caproate Injections in the member's medical record in addition to sending the completed form to ForwardHealth. The provider is required to sign and date a new Attestation to Administer Alpha Hydroxyprogesterone (17P) Caproate Injections each time an injection is administered.

To be reimbursed for the 17P 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 J3490 (Unclassified drugs). (*Note:* Procedure code J3490 may also be indicated on claims for other injections.)
- The NDC and description from the bulk powder used to compound the 17P injection.
- The name of the person who administered the injection on the same detail line as procedure code J3490.

The 17P 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 injection. Claims with other diagnosis codes indicated will be denied.

The claim for the 17P injection may be submitted to ForwardHealth by mail. The provider's usual and customary charge should be indicated on the claim.

Reimbursement

The maximum allowable rate for the 17P injection is $22.66 per injection, which does not include reimbursement for the administration of the drug.

Providers may be reimbursed for the administration of the 17P 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 injection is $3.31.

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.

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 Codes

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

Chiropractic Codes

- 98940-98942.

Health and Behavior Assessment/Intervention Codes

- 96150-96154.

Psychiatric Codes

- 90801-90845.
- 90847.
- 90853-90862.
- 90875-90880.

Vision Codes

- 92002-92014.

Visits will not count toward the 10-visit limit when provided in the following POS:

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

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.

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 are not covered under the Benchmark Plan.

Certificate of Need for Transportation

ForwardHealth covers SMV 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 form.

SMV services are not covered under the BadgerCare Plus Benchmark Plan.

If the member does not meet the criteria for SMV services, the medical provider should not complete the form. Instead, the provider should refer the member to the Medicaid transportation coordinator in his or her county/tribal social or human services agency.

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 CPT procedure code if the member is in the office when the form is completed and no other medical service is provided.

Prescriptions are required for SMV trips that exceed the one-way upper mileage limits.

Cochlear and Bone-Anchored Hearing Aid Surgeries

The rendering provider is required to obtain PA for the cochlear or bone-anchored hearing aid 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. 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.

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 certified as a DME provider.

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 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 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.

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 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.

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, 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.

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.

Core Plan Health Care Education Benefit

Effective for DOS on and after January 1, 2010, health care education on patient self-management for members diagnosed with asthma, diabetes, or hypertension will be 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 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 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 dieticians.
- 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 certified by Medicaid, claims for these services provided by ancillary providers are required to be submitted under the supervising provider's NPI using the appropriate code for the service. Health care education services may be billed on the same DOS as an E&M visit.

Allowable Procedure Codes

The new benefit will correspond to the CPT 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.

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.

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.

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 or other program requirements may be waived in emergency situations.
- Noncertified providers may be reimbursed for emergency services.
- Non-U.S. citizens may be eligible for covered services in emergency situations.

Emergency Room Covered and Noncovered Services Under the Basic Plan

Information is available for DOS before January 1, 2011.

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.

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 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.
- 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 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 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

Information is available for DOS from December 1, 2009, to April 30, 2010.

Cervarix® is a covered service for female members ages 9 to 26 years of age. Cervarix is available through VFC program therefore providers should submit claims with HCPCS 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 does 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.

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.

Member Payment for Covered Services

Under state and federal laws, a Medicaid-certified 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 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 certification.

Not Otherwise Classified Drugs

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

- The NDC of the drug dispensed.
- The name of the drug.
- The quantity billed.
- The unit of issue (i.e., ea, gm, or ml).

If this information is not included on the claim or if there is a more specific HCPCS procedure code for the drug, the claim will be denied. Compound drugs that do not include a drug approved by the FDA will be denied.

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

Program Requirements

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

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) or incidental to a physician service. 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 and CPT procedure codes for provider-administered drugs and reimbursement rates.

For Dates of Service On and After January 1, 2009

For DOS on and after January 1, 2009, for members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, BadgerCare Plus and Medicaid fee-for-service, not the member's MCO, 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, 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 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. If a member is given a drug to be administered by the provider for which storage, handling, and care instructions apply and the instructions are followed incorrectly, the dose may be ineffective. 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.

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.
- 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 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.

Services That Do Not Meet Program Requirements

As stated in DHS 107.02(2), Wis. Admin. Code, BadgerCare Plus 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, the PRO 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 certification 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.

Telemedicine

Information for DOS before January 1, 2009, is available.

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-certified 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 confidentiality requirements apply to telemedicine encounters.

Reimbursable Telemedicine Services

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

- Physicians and physician clinics.
- RHCs.
- FQHCs.
- 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 procedure codes 99201-99205, 99211-99215).
- Office or other outpatient consultations (CPT codes 99241-99245).
- Initial inpatient consultations (CPT codes 99251-99255).
- Outpatient mental health services (CPT codes 90801-90849, 90862, 90875, 90876, and 90887).
- Health and behavior assessment/intervention (CPT codes 96150-96152, 96154-96155).
- ESRD-related services (CPT codes 90951-90952, 90954-90958, 90960-90961).
- Outpatient substance abuse services (HCPCS codes H0022, H0047, T1006).

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

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 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 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 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-eligible services performed via telemedicine in the same manner as face-to-face contacts. As with face-to-face visits, HPSA-enhanced reimbursement is allowed when either the member resides in or the provider is located in a HPSA-eligible ZIP code. Providers may submit claims for services performed through telemedicine that qualify for pediatric or HPSA-enhanced reimbursement with both modifier "GT" and the applicable pediatric or HPSA modifier.

Originating Site Facility Fee

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

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

Claim Submission

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

Code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Facilities for Developmental Disabilities
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Nonresidential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

Outpatient Hospital Reimbursement

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

Store and Forward Services

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

Evaluation and Management

A Comprehensive Overview

E&M 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.

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.

Concurrent Care

BadgerCare Plus covers E&M services provided on the same DOS 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.

Consultations

Inpatient and outpatient office consultations (CPT 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 code for the POS.

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.

Critical Care and Prolonged Services

Wisconsin Medicaid reimburses up to four hours per DOS for critical care (CPT 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 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.

Documentation

BadgerCare Plus has adopted the federal CMS 1995 and 1997 Documentation Guidelines for Evaluation and Management Services in combination with BadgerCare Plus policy for E&M 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.

Emergency Department Services

Physician services providers may receive reimbursement for an emergency E&M service (CPT codes 99281-99285) in addition to any surgical procedures or consultations performed by the same performing provider for the same member on the same DOS. 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.

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 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 form for the allowed surgery claim to request additional reimbursement for the E&M 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.

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:

- Diagnosis code from V25 series.
- Appropriate diagnosis code reference to procedure code.
- Family Planning Indicator "Y."

Hospital Services

Wisconsin Medicaid ordinarily reimburses physicians for a moderate-level hospital admission procedure code if the physician has provided an E&M service or consultation at the highest level of service in the seven days prior to the hospital admission date.

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 procedure code based on the level of service provided.

Observation Care

Observation care procedure codes 99217-99220 or 99234-99236 are covered. Observation care includes all E&M 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 procedure code. Only one observation care procedure code may be reimbursed per member, per DOS, per provider. Observation care codes are not reimbursed for members admitted into hospital inpatient care on the same DOS. Only POS codes "22" (outpatient hospital) and "23" (emergency room - hospital) may be indicated on claims for observation care.

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. However, an established patient office visit may be reimbursed in addition to a preventive medicine office 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 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 code "11" (office).

Office Visits and Counseling

A physician or a physician's designee may be reimbursed for counseling (including counseling a recipient 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.

Preventive Medicine Services

Preventive medicine services are those office visits that relate to preventive medicine E&M 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. 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.

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 E&M services (procedure codes 99201-99205 and 99211-99215) with an ICD-9-CM diagnosis code applicable for mental health and/or substance abuse services. As a reminder, these services may be eligible for HPSAs and pediatric enhanced reimbursements.

Refer to the latest edition of CPT or to the CMS 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 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 of the supervising physician. Coverage and reimbursement are limited to CPT code 99211 or 99212 as appropriate.

Tobacco Cessation Drugs and Services

Tobacco cessation services are reimbursed as part of an E&M 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-certified physician. When ancillary staff provide tobacco cessation services, BadgerCare Plus reimburses up to a level-two office visit (CPT code 99212). The supervising provider is required to be listed as the rendering provider on the claim.

Drugs for Tobacco Cessation

BadgerCare Plus and Medicaid

The Standard Plan and Medicaid cover legend drugs for tobacco cessation.

The Benchmark Plan and 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.

A written prescription from a prescriber is required for both federal legend *and* OTC tobacco cessation products. Prescribers are required to indicate the appropriate diagnosis on the prescription. PA is required for uses outside the approved diagnosis (ICD-9-CM diagnosis code 305.1).

HealthCheck "Other Services"

Definition of HealthCheck "Other Services"

HealthCheck is a federally mandated program known nationally as EPSDT. 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 by 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.

Prior Authorization

To receive PA 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 (or PA/DRF, or PA/HIAS1).
  - 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.

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 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.

BadgerCare Plus 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

Allergy Tests

Claims for allergy tests must include the appropriate CPT procedure code(s) and the quantities of items provided or tests performed.

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, 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. 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.

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.

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 (CPT codes 96100-96117) for one DOS.

Certificate of Need Requirements for Members Admitted to an Institution for Mental Disease

Federal and state regulations require IMDs to conduct and document a CON 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 or DHS review:

- Certification of Need for Elective Urgent Psychiatric Substance Abuse Admissions to Hospital Institutions for Mental Disease for Recipients Under Age 21.
- Certification of Need for Emergency Psychiatric/Substance Abuse Admissions to Hospital Institutions for Mental Disease for Members Under Age 21 and in Cases of Medicaid Determination After Admissions.

Chemotherapy

When chemotherapy for a malignant disease is provided in a physician's office, separate reimbursement is allowed for the following:

- E&M 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 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.

End-Stage Renal Disease Services

Physician services providers should submit claims with CPT procedure codes 90951-90970 for professional ESRD-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 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 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.

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 (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.

Fluoride — Topical Applications

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 mouth rinses are not covered.

Submitting Claims

When submitting claims for topical fluoride treatment, indicate HCPCS procedure code D1203 (Topical application of fluoride [prophylaxis not included]; child). 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

Training materials 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.

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 recipient, per outside laboratory, per DOS, 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.

Mental Health Services

Except for biofeedback and pharmacological management, Mental Health Services are reimbursable only for Medicaid-certified physicians with a psychiatric specialty.

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 coding book for descriptions.

Diagnosis Restrictions

Diagnosis restrictions that apply to NDCs also apply to corresponding HCPCS codes when billed as provider-administered drugs. Wisconsin Medicaid requires a valid and acceptable ICD-9-CM diagnosis code on claims for selected provider-administered drugs. Diagnosis code restrictions are based on FDA-approved indications and compendium standards.

BadgerCare Plus has identified a list of drugs that are diagnosis restricted and the respective HCPCS codes, allowable diagnosis codes, and disease descriptions. This list may be updated periodically.

Code	Drug Name	Diagnosis Code	Disease Description
J0205	Alglucerase (Ceredase)	2727	Gaucher's Disease
J0585	Botulinum Toxin Type A (Botox)	3336	Idiopathic dystonia
		3337	Symptomatic torsion dystonia
		33381	Blepharospasm
		33383	Spasmodic torticollis
		33384	Focal hand dystonia
		34211	Spastic hemiplegia and hemiparesis affecting dominant side
		34212	Spastic hemiplegia and hemiparesis affecting nondominant side
		3440-34404, 34409	Quadriplegia
		3441	Paraplegia
		340	Multiple Sclerosis
		3430-3439	Cerebral palsy
		3518	Facial spasm
		3780-37887	Strabismus
		70521	Hyperhidrosis
		72885	Spasm of muscle
		7810	Hemifacial spasm
J0587	Botulinum Toxin Type B (Myobloc)	33383	Spasmodic torticollis
J0880 and Q4054	Darbepoetin alfa in albumin solution (Aranesp)	042, 07953	Anemia from Acquired Immune Deficiency Syndrome (AIDS)
		140-20491, 230-2386, 2388-2399, 2733	Non-myeloid malignancies or multiple myeloma
		20610	Chronic myelomonocytic leukemia
		2387, 2849, 2850	Myelodysplastic syndrome
		28521	Anemia in end-stage renal disease
		28522	Anemia in neoplastic disease
		585	Chronic renal failure
J1440	Filgrastim (Neupogen), 300 mcg	2880	Agranulocytosis/Neutropenia
J1441	Filgrastim (Neupogen), 480 mcg	2880	Agranulocytosis/Neutropenia

J1595	Glatiramer acetate (Copaxone)	340	Multiple Sclerosis
J1785	Imiglucerase (Cerezyme)	2727	Gaucher's Disease
J1825	Interferon Beta 1A (Avonex)	340	Multiple Sclerosis
J1830	Interferon Beta 1B (Betaseron)	340	Multiple Sclerosis
J2505	Pegfilgrastim (Neulasta)	2880	Agranulocytosis/Neutropenia
J2820	Sargramostim (Leukine)	205	Myeloid leukemia
J7505	Muromonab CD 3 (Orthoclone OKT-3)	9968	Organ transplant failure or rejection
J9212	Interferon Alfacon 1 (Infergen)	07054	Chronic hepatitis C without mention of hepatic coma
J9213	Interferon Alfa 2A (Roferon-A)	07054	Chronic hepatitis C without mention of hepatic coma
		1729	Malignant melanoma
		1760-1769	Kaposi's sarcoma
		2024	Hairy cell leukemia
		2028	Non-hodgkin's lymphoma
		2030	Multiple myeloma
		2051	Chronic myelocytic leukemia
		2337	Bladder carcinoma
		2339	Renal cell carcinoma
J9214	Interferon Alfa 2B (Intron A)	07054	Chronic hepatitis C without mention of hepatic coma
		07811	Condyloma acuminatum
		1729	Malignant melanoma
		1760-1769	Kaposi's sarcoma
		2024	Hairy cell leukemia
		2028	Non-hodgkin's lymphoma
		2030	Multiple myeloma
		2337	Bladder carcinoma
		2339	Renal cell carcinoma
J9215	Interferon Alfa N3 (Alferon N)	07811	Condyloma acuminatum
J9216	Interferon Gamma 1B (Actimmune)	2881	Chronic granulomatous disease
		75652	Osteopetrosis
Q0136 and Q4055	Epoetin (Epogen and Procrit)	042, 07953	Anemia from Acquired Immune Deficiency Syndrome (AIDS)
		140-20491, 230-2386, 2388-2399, 2733	Non-myeloid malignancies or multiple myeloma
		20610	Chronic myelomonocytic leukemia
		2387, 2849, 2850	Myelodysplastic syndrome
		28521	Anemia in end-stage renal disease
		585	Chronic renal failure
Q3026	Interferon Beta 1A in Albumin (Rebif)	340	Multiple Sclerosis

If the member's diagnosis is not one of the allowable diagnoses for the code, providers are required to obtain PA.

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 one of the allowable diagnosis codes listed above. Providers are required to use the PA/JCA along with the PA/RF 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 listed in the previous table 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 for the same provider-administered drug, unless otherwise noted in the procedure code description.

Psychiatric Medication Checks

Providers who are not certified as mental health providers and who perform medication checks for psychiatric patients are required to use HCPCS 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).

Providers of mental health services (e.g., psychiatrists, psychotherapists, or social workers) are required to use CPT code 90862 (Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy) for medication checks on psychiatric patients.

Claims submitted with the incorrect procedure code and provider type combination will be denied.

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.
- 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 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 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 recipient'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 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 — This test is a routine clinical examination of an asymptomatic individual's prostate for nodules or other abnormalities of the prostate.
- Screening PSA 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 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.

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.

Synagis® Coverage

Synagis® (palivizumab), a monoclonal antibody, is used to prevent lower respiratory tract diseases caused by RSV 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 is required for Synagis®.

Synagis® is not part of the provider-administered drugs carve-out policy; therefore, a member's MCO should reimburse providers for Synagis®.

Claims for Synagis® must be submitted using the 837P transaction or on the 1500 Health Insurance Claim Form. Prescribers and pharmacy providers are required to indicate CPT procedure code 90378 (Respiratory syncytial virus immune globulin [RSV-IgIM], for intramuscular use, 50 mg, each) and the appropriate unit(s) on each claim submission.

Providers should *not* indicate HCPCS procedure code J3490 (Unclassified drugs) on claims submitted to ForwardHealth for Synagis®. Claims submitted for Synagis® with HCPCS procedure code J3490 will be denied.

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. 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 procedure code. For weight management services, food supplements, and dietary supplies (e.g., liquid or powdered diet foods or supplements, OTC 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

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 Standard Plan, the Benchmark Plan, and Wisconsin Medicaid unless otherwise specified. Women enrolled in an HMO must receive the services through the HMO. These services do not require PA 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 certified 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:

- Edinburgh Postnatal Depression Scale (EPDS). The EPDS is available in English, Spanish and Hmong at the Perinatal Foundation/Wisconsin Association for Perinatal Care Web site.
- Beck Depression Inventory-II (BDI-II). The BDI-II is available for a fee through the Harcourt Assessment, Inc., Web site.
- Center for Epidemiologic Studies Depression Scale (CES-D). The CES-D is available through the Stanford Patient Education Research Center.
- The nine item depression scale of the Patient Health Questionnaire (PHQ-9). 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.
- Tolerance, Annoyance, Cut down, Eye opener (T-ACE) screen. The T-ACE screen is available through the Project Cork Web site.

- Tolerance, Worry, Eye opener, Amnesia, Cut down (TWEAK) screen. The TWEAK screen is available through the Project Cork Web site.
- The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST). This screen is available through the World Health Organization.

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:

- Screening, Brief Intervention and Referral to Treatment (SBIRT). 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.

Coverage Limitations

Mental Health and Substance Abuse Screening

The screening (HCPCS 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 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. 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.

Documentation Requirements

Providers are required to retain documentation that the member receiving these services was pregnant on the DOS. 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.

Eligible Providers

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

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

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

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

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

* This table includes the HCPCS procedure codes and modifiers that correspond with the screening, counseling, and intervention services.

Procedure Codes and Modifiers

The following tables list the HCPCS 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 Care 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** Diagnosis**	**Allowable Place of Service**
H0002 Mental Health and Substance Abuse Screening	Behavioral health screening to determine eligibility for admission to treatment program (Unit equals one, regardless of time)	HE (Mental health program) or HF (Substance abuse program)	Limited to one unit per member per pregnancy.	V28.9 (Unspecified antenatal screening)	03, 11, 12, 21*, 22, 23, 99
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.

** *International Classification of Diseases, Ninth Revision, Clinical Modification.*

Noncovered Services

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.
- 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).
- Inpatient mental health and substance abuse treatment services.
- Non-emergency transportation (i.e., common carrier, SMV).
- Nursing home.
- Obstetrical care and delivery.
- Outpatient mental health and substance abuse services.
- PNCC.
- Provider-administered drugs.
- Routine vision examinations billed with CPT 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.
- 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.

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.

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 at the request of Wisconsin Medicaid.

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 does not allow state Medicaid programs to permit providers to collect payment from a member, or authorized person acting on behalf of the member, for a missed appointment.

Avoiding Missed Appointments

ForwardHealth offers the following suggestions to help avoid missed appointments:

- Remind members of upcoming appointments (by telephone or postcard) prior to scheduled appointments.
- Encourage the member to call his or her local county or tribal agency if transportation is needed.
- 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

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.

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.

Cesarean Sections

Nationally, the number of scheduled, elective cesarean sections has increased steadily. To ensure that the DHS 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.
- 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).

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.

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 obstetric procedure code and a single charge for the service. Use the date of delivery as the DOS.

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.

Health Professional Shortage Area-Enhanced Reimbursement

Many obstetric procedure codes are eligible for the HPSA-enhanced reimbursement.

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 FFS or through a BadgerCare Plus or Medicaid HMO or SSI HMO.

A member who is initially eligible for BadgerCare Plus FFS 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 FFS payment for the antepartum care. If this is the case, the provider is required to submit an adjustment request to have the FFS payment recouped.

If the provider does not submit an adjustment request in this situation, Wisconsin Medicaid will recoup the FFS 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 FFS that is more than the global fee or the combined maximum allowable fee for the services if billed separately.

Newborn Reporting

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

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.

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 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. 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 ... Usually, the presenting problem(s) is of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.	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 ... Usually, the presenting problem(s) is of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.	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 CPT 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.

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).

Unrelated Conditions

Any E&M 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.

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 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

An Overview

Definition

The SBIRT 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. These services do not require PA 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 a 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 communication 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 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. This screen is a reliable tool for use to determine the level of alcohol use. The AUDIT screen is available through the WHO Web site.
- The DAST. 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. This screen is available through the WHO Web site.
- The CRAFFT screening tool developed by John Knight at the CeASAR. The CRAFFT screening tool is available through the CeASAR Web site. This screen is valid for use with children and adolescents.
- The POSIT. This screen is valid for use in adolescents in a medical setting. A POSIT PC tool is available through the Power Train, Inc. 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. HHS.
- "Helping Patients Who Drink Too Much," A Clinician's Guide, Updated 2005 Edition, available through the U.S. HHS.

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 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. 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.

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 Certification and Ongoing Responsibilities section of the appropriate Online Handbook for more information about additional documentation requirements.

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-certified providers to administer the SBIRT 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-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.

Procedure Codes and Diagnosis Codes

The following tables list the HCPCS 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 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

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: 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 a completed and signed certification statement attesting to one of the previous circumstances. The optional Abortion Certification Statements 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 code S0190 (Mifepristone, oral, 200 mg) for the first dose of Mifeprex, 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.
- 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 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.

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 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.

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.

Bariatric Surgery

Criteria for Coverage of All Bariatric Procedures

Comorbidities

Providers are required to submit with a PA request clinically documented evidence that a continued comorbid clinical status will lead to serious impairment of the member's health, and treatment of the comorbid condition for a minimum of three months has not improved the health risks and impairments.

Such comorbid conditions undergoing current appropriate therapy trials would include, for example, but not be restricted to, congestive heart failure, recurrent venous thrombosis with or without pulmonary emboli, uncontrolled diabetes mellitus or demonstrated coronary artery disease with hemodynamically significant arteriolar occlusion leading to documented myocardial dysfunction.

Facility Requirements

BadgerCare Plus requires all bariatric surgery procedures to be performed at a facility that is Medicaid certified and meets 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.

Claims for bariatric services from a hospital that does not meet the above criteria will be denied.

A current list of approved facilities in included in the following table. As this list may change at any time, providers are advised to check for revisions to the list at *cms.hhs.gov/MedicareApprovedFacilitie/BSF/list.asp*.

Facility Name	City	Date Approved
Aspirus Wausau Hospital	Wausau	11/28/2007
Aurora Sinai Medical Center	Milwaukee	02/24/2006
Bellin Health	Green Bay	02/24/2006
Columbia St. Mary's Bariatric Center	Milwaukee	02/24/2006
Elmbrook Memorial Hospital	Brookfield	02/24/2006
Froedtert Memorial Lutheran Hospital	Milwaukee	02/24/2006
Gundersen Lutheran Medical Center	La Crosse	02/13/2007
Meriter Hospital	Madison	12/19/2006
Theda Clark Medical Center	Neenah	02/24/2006
University of Wisconsin Hospital and Clinics	Madison	12/19/2006

Laparoscopic Adjustable Gastric Banding

BadgerCare Plus covers LAGB (CPT procedure codes 43770-43774). Coverage of LAGB is subject to the same approval criteria as other covered bariatric procedures.

Prior Authorization Approval Criteria

All BadgerCare Plus-covered bariatric surgery procedures (CPT procedure codes 43644-43645, 43659, 43770-43774, 43842-43843, 43846-43848) require PA. As a reminder, PA requests must be submitted by physicians, and claims must be submitted by facilities. If a PA is not on file when the claim is submitted, the claim will be denied. The approval criteria for PA requests for BadgerCare Plus-covered bariatric surgery procedures include all of the following:

- The member must have one of the following:
  - A BMI of 40 or greater (include clinical documentation that a continued morbidly obese status will lead to serious impairment of the member's health because of comorbid conditions that cannot be optimally corrected with current therapy) with a demonstrated and documented trial of a minimum of three months.
    i. Such comorbid conditions undergoing current appropriate therapy would include, but not be limited to, congestive heart failure, recurrent venous thrombosis with or without pulmonary emboli, uncontrolled diabetes mellitus, or demonstrated coronary artery disease with hemodynamically significant arteriolar occlusion leading to myocardial dysfunction.
    ii. A three-month period of a physician-supervised program including dietary counseling, behavioral modification, and supervised exercise, plus a psychiatric evaluation prior to surgery would be required for those members whose clinical status is stable. This would provide time to stabilize the member's current clinical status, and educate the member through behavioral modification related to eating habits, appropriate exercise, and psychological support to assure the greatest success with weight control after surgery.
  - A BMI between 35 and 39 with documented high-risk comorbid medical conditions that have not responded to medical

management and are a threat to life, such as, but not limited to clinically significant obstructive sleep apnea, Pickwickian syndrome, obesity-related cardiomyopathy, coronary heart disease, or medically refractory hypertension.

- Documentation that the member has attempted weight loss in the past without successful long-term weight reduction. These attempts may include, but are not limited to, diet restrictions or supplements, behavior modification, physician-supervised weight loss plans, physical activity programs, commercial or professional programs, and pharmacological therapy.
- For all members who are stable without documented life-threatening comorbidities, documentation must be presented that the member has clinically documented evidence of a minimum of six months of demonstrated adherence to a physician-supervised weight management program including at least three consecutive months of participation in a weight management program prior to the date of surgery in order to improve surgical outcomes, reduce the potential for surgical complications and establish the member's ability to comply with post-operative medical care and dietary restrictions. A physician's summary letter is not sufficient documentation. Documentation must include assessment of the member's participation and progress throughout the course of the program. The member must also agree 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 monitoring.
- The member should receive 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 and clearance to determine 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.
  - Members receiving active treatment for a psychiatric disorder must receive evaluation by their treatment provider prior to bariatric surgery and be cleared for bariatric surgery.
  - Dietary assessment and counseling.
- The member must be 18 years of age or older and have completed growth.
- The member must have a BMI of 50 or less for approval of LAGB (43770-43774).

All of the following must be included in the PA request:

- A completed PA/RF.
- A completed PA/PA.
- Clinical documentation supporting the criteria.

The following procedures are considered investigational, inadequately studied, or unsafe and therefore are not covered:

- Gastric balloon.
- Biliopancreatic bypass.
- Loop gastric bypass.

Bone-Anchored Hearing Devices

Prior Authorization Approval Criteria and Documentation Requirements for Surgical Implant of Bone-Anchored Hearing Devices

The PA approval criteria and documentation requirements for bone-anchored hearing device surgery are as follows:

- The member is approximately 5 years of age or older at the time of surgery.
- The member has a conductive and/or mixed hearing loss (unilateral or bilateral).
- The member demonstrates a pure tone average bone conduction threshold of up to 70 dB.
- The member demonstrates a word recognition score greater than 60 percent with the use of amplification.

- The member has 3mm or greater of bone thickness at the implant site.
- The patient has one of the following conditions:
  - Severe, chronic external otitis or otitis media.
  - Chronic draining ear through a tympanic membrane perforation.
  - Congenital or surgically induced malformation of the external auditory canal or middle ear.
  - Acquired 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 in the ear to be implanted, or where the condition prevents restoration of hearing using a conventional air-conductive hearing aid.

Breast Reconstruction

Breast reconstruction requires PA; however, PA is *waived* for breast reconstruction when performed following a mastectomy for breast cancer. (Breast reconstruction is identified by CPT 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 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.

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 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 recipient'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 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.

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 and HCPCS 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.

Cochlear and Bone-Anchored Implant Surgeries

The performing surgeon is required to obtain PA for the cochlear or bone-anchored hearing device implant surgeries. Wisconsin Medicaid will deny claims for services relating to the surgery unless there is an approved PA request on file from the performing surgeon for the surgery.

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-certified as a DME provider.

Prior Authorization Approval Criteria and Documentation Requirements for Cochlear Implant Surgery

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 or poorer for 1000 Hz 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 for children 25 months to 5 years of age, and an aided score of 30 percent or less on the LNT 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 team.
- There is radiographic evidence (CT and/or MRI) 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.

Contraceptive Implants

Contraceptive implant devices are covered. Reimbursement for the contraceptive implant CPT procedure codes 11975, 11976, or 11977 includes the E&M service, supplies, and the cost of the device.

Providers should not submit claims for E&M services and supplies associated with contraceptive implant services, unless another separate and distinct service is provided and documented in the member's medical record.

Informed Consent Procedure

Wisconsin Medicaid 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, Wisconsin Medicaid 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 capsules may occur making removal difficult.
- Women can request the implant be removed at any time.
- The implant does not provide protection against sexually transmitted diseases.

Wisconsin Medicaid 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.

Informed Consent Documentation

Informed consent should be documented in the member's medical record and must include the signatures or initials of both the

provider and the member.

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.

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.

Hysterectomies

An Acknowledgment of Receipt of Hysterectomy Information form must be completed prior to a covered hysterectomy, except in the circumstances noted below.

The form must be attached to the 1500 Health Insurance Claim Form. Wisconsin Medicaid does not cover a hysterectomy for uncomplicated fibroids, fallen uterus, or retroverted uterus.

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

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

applied:

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

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

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

Intrauterine Devices

Wisconsin Medicaid reimburses physicians separately for the IUD and IUD insertion and removal procedures. Reimbursement for the E&M 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.

Organ Transplants

Wisconsin Medicaid reimburses physicians and transplant centers (hospitals) for organ transplants when they are:

- Medically necessary.
- Prior authorized (with the exception of kidney and cornea transplants which do not require PA).
- Performed in an approved UNOS 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, Wisconsin Medicaid recommends that physicians verify that the transplant center currently accepts Wisconsin Medicaid recipient referrals and Medicaid reimbursement for the proposed transplant.

Prior Authorization Requirements

For all transplants requiring 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.

In cases of multiple organ transplants where no single CPT code describes the procedure performed, indicate each individual procedure code, if available, on the PA request.

Physicians should *not* indicate the PA number on the claim for the transplant surgery.

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 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:
    - In the case of premature delivery, the sterilization is performed at the time of premature delivery *and* written informed consent was given at least 30 days before the expected date of delivery *and* at least 72 hours before the premature delivery. The 30 days excludes the consent and surgery dates.
    - The sterilization is performed during emergency abdominal surgery *and* at least 72 hours have passed since the member gave written informed consent for sterilization.

Consent for Sterilization Form

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

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

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

The completed consent form must be attached to a paper 1500 Health Insurance Claim Form to obtain reimbursement.

Sterilization with Placement by Permanent Implant

Information for DOS before May 1, 2010, is available.

The professional service for CPT procedure code 58565 (Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants) and the implantable device is reimbursed under separate procedure codes.

The professional service only is reimbursed under procedure code 58565. The implantable device is reimbursed under HCPCS 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.

Temporomandibular Joint Surgery

Providers may submit claims for assessing TMJ dysfunction using an E&M visit procedure code. A TMJ office visit generally consists of the following for a recipient experiencing TMJ dysfunction:

- Comprehensive history.

- Detailed and extensive clinical examination.
- Diagnosis.
- Treatment planning.

Allowable Procedure Codes

The following are allowable TMJ procedure codes:

- *Surgery services* — 20910, 20962, 21010, 21050, 21060, 21070, 21240, 21242, 21243, 29800, 29804.
- *Anesthesia services* — 00190, 00192, 00470, 01250, 01320, 01470, 01610, 01710, 01810.

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 for TMJ surgery.

The surgeon who will perform the TMJ surgery requests PA by using the PA/RF, the PA/PA, 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 or SSI 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.

Vagal Nerve Stimulators

Performing surgeons are required to obtain PA from Wisconsin Medicaid for vagal nerve stimulator implant surgeries. Wisconsin Medicaid will deny claims for services relating to the surgery unless there is an approved PA request on file from the performing surgeon for the surgery.

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-certified as a DME provider.

Managed Care

5

Archive Date:03/01/2011

Managed Care:Claims

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 or SSI 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 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.

Appeals to HMOs and SSI HMOs

Providers are required to first file an appeal directly with the BadgerCare Plus HMO or Medicaid SSI 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.

Claims Submission

BadgerCare Plus HMOs and Medicaid SSI 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.

Extraordinary Claims

Extraordinary claims are BadgerCare Plus or Medicaid claims for a BadgerCare Plus HMO or Medicaid SSI HMO enrollee that have been denied by an HMO or SSI HMO but may be paid as fee-for-service claims.

The following are some examples of extraordinary claims situations:

- The enrollee was not enrolled in an HMO or SSI HMO at the time he or she was admitted to an inpatient hospital, but then enrolled in an HMO or SSI HMO during the hospital stay. In this case, all claims related to the stay (including physician claims) should be submitted to fee-for-service. For the physician claims associated with the inpatient hospital stay, the provider is required to include the date of admittance and date of discharge in Element 18 of the paper 1500 Health Insurance Claim Form.
- The claims are for orthodontia/prosthodontia services that began before HMO or SSI HMO coverage. Include a record with the claim of when the bands were placed.

Submitting Extraordinary Claims

When submitting an extraordinary claim, include the following:

- A legible copy of the completed claim form, in accordance with billing guidelines.
- A letter detailing the problem, any claim denials, and any steps taken to correct the situation.

Submit extraordinary claims to:

ForwardHealth
Managed Care Extraordinary Claims
PO Box 6470
Madison WI 53716-0470

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 or Medicaid SSI 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.

Provider Appeals

When a BadgerCare Plus HMO or Medicaid SSI 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 MCO 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

Covered Services

HMOs

HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements. Although BadgerCare Plus requires contracted HMOs and Medicaid SSI HMOs to provide all medically necessary covered services, the following services may be provided by BadgerCare Plus HMOs at their discretion:

- Dental.
- Chiropractic.

If the HMO does not include these services in their benefit package, the enrollee receives the services on a fee-for-service basis.

Noncovered Services

The following are not covered by BadgerCare Plus HMOs or Medicaid SSI HMOs but are provided to enrollees on a fee-for-service basis provided the member's fee-for-service plan covers the service:

- CRS.
- CSP benefits.
- Crisis intervention services.
- Environmental lead inspections.
- CCC services.
- Pharmacy services and some drug-related supplies.
- PNCC services.
- Provider-administered drugs, including all "J" codes, drug-related "Q" codes, and a limited number of related administration codes.
- SBS.
- Targeted case management services.
- Transportation by common carrier (unless the HMO has made arrangements to provide this service as a benefit). Milwaukee HMOs and SSI HMOs are mandated to provide transportation for their enrollees.
- Directly observed therapy and monitoring for TB-only.

Enrollment

Disenrollment and Exemptions

In some situations, a member may be exempt from enrolling in a BadgerCare Plus HMO or Medicaid SSI HMO. Exempted members receive health care under fee-for-service. Exemptions allow members to complete a course of treatment with a provider who is not contracted with 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 and the HMO or SSI HMO provide more detail on the exemption and disenrollment requirements.

Enrollee Grievances

Enrollees have the right to file grievances about services or benefits provided by a BadgerCare Plus HMO or Medicaid SSI HMO. Enrollees also have the right to file a grievance when the HMO or SSI HMO refuses to provide a service. All HMOs and SSI HMOs are required to have written policies and procedures in place to handle enrollee grievances. Enrollees should be encouraged to work with their HMO's or SSI HMO's customer service department to resolve problems first.

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

The contracts between the DHS and the HMO or SSI HMO describes the responsibilities of the HMO or SSI HMO and the DHS regarding enrollee grievances.

Enrollment Eligibility

BadgerCare Plus HMOs

Members enrolled in the BadgerCare Plus Standard Plan and the BadgerCare Plus Benchmark Plan are eligible for enrollment in a BadgerCare Plus HMO. BadgerCare Plus Core Plan members are enrolled in BadgerCare Plus HMOs.

An individual who receives Family Planning Only Services, the TB-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 or the ForwardHealth Portal.

SSI HMOs

Members of the following subprograms are eligible for enrollment in a Medicaid SSI HMO:

- Individuals ages 19 and older, who meet the SSI and SSI-related disability criteria.
- Dual eligibles for Medicare and Medicaid.

Individuals who are living in an institution, nursing home, or participating in a Home and Community-Based Waiver program are not eligible to enroll in an SSI MCO.

Enrollment Periods

HMOs

Members are sent enrollment packets that explain the BadgerCare Plus HMOs 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 HMO's enrollment process and provide contract 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.

Enrollment Specialist

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

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

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

Member Enrollment

HMOs

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

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

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

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

SSI HMOs

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

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

- Voluntary enrollment — Some SSI and SSI-related members may choose to enroll in an SSI HMO on a voluntary basis.

Ombudsman Program

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

BadgerCare Plus HMO/Medicaid SSI HMO Ombudsmen
PO Box 6470
Madison WI 53716-0470

Release of Billing or Medical Information

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

Managed Care Information

BadgerCare Plus HMO Program

An HMO is a system of health care providers that provides a comprehensive range of medical services to a group of enrollees. HMOs receive a fixed, prepaid amount per enrollee from BadgerCare Plus (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, claims submission, adjudication procedures, etc., which may differ from BadgerCare Plus fee-for-service policies and procedures. BadgerCare Plus HMO network providers should contact their HMO for more information about its policies and procedures.

Managed Care

Managed Care refers to the BadgerCare Plus HMO program, the Medicaid SSI 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.

Managed Care Contracts

The contract between the DHS and the BadgerCare Plus HMO or Medicaid SSI 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.

SSI HMO Program

Medicaid SSI HMOs 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 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.

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, 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

Prior Authorization Procedures

BadgerCare Plus HMOs and Medicaid SSI HMOs may develop PA 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

Copayments

Providers cannot charge Medicaid SSI HMO enrollees copayments for covered services except in cases where the Medicaid SSI HMO does not cover services such as dental, chiropractic, and pharmacy. When services are provided through fee-for-service or to members enrolled in a BadgerCare Plus HMO, copayments will apply.

Emergencies

Non-network providers may provide services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees in an emergency without authorization or in urgent situations when authorized by the HMO or SSI HMO. The contract between the DHS 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.

Non-network Providers

Providers who do not have a contract with the enrollee's BadgerCare Plus HMO or Medicaid SSI HMO are referred to as non-network providers. (HMO and SSI HMO network providers agree to payment amounts and billing procedures in a contract with the HMO or SSI HMO.) Non-network providers are required to direct enrollees to HMO or SSI HMO network providers except in the following situations:

- When a non-network provider is treating an HMO or SSI HMO enrollee for an emergency medical condition as defined in the contract between the DHS 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.

Out-of-Area Care

BadgerCare Plus HMOs and Medicaid SSI HMOs may cover medically necessary care provided to enrollees when they travel outside the HMO's or SSI HMO's service area. The HMO or SSI HMO is required to authorize the services before the services are provided, except in cases of emergency. If the HMO or SSI HMO does not authorize the services, the enrollee may be held responsible for the cost of those services.

Provider Participation

Providers interested in participating in a BadgerCare Plus HMO or Medicaid SSI HMO or changing HMO or SSI HMO network affiliations should contact the HMO or SSI HMO for more information. Conditions and terms of participation in an HMO or SSI HMO are pursuant to specific contract agreements between HMOs or SSI HMOs and providers. An HMO or SSI HMO has the right to choose whether or not to contract with any provider.

Referrals

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

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

Services Not Provided by HMOs or SSI HMOs

If an enrollee's BadgerCare Plus HMO's or Medicaid SSI HMO's benefit package does not include a covered service, such as chiropractic or dental services, any Medicaid-certified provider may provide the service to the enrollee and submit claims to fee-for-service.

Member Information

6

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Member Information:Birth to 3 Program

Administration and Regulations

In Wisconsin, B-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 monitors, provides technical assistance, and offers other services to county B-3 agencies.

The enabling federal legislation for the B-3 Program is 34 CFR Part 303. The enabling state legislation is s. 51.44, Wis. Stats., and the regulations are found in ch. DHS 90, Wis. Admin. Code.

Providers may contact the appropriate county B-3 agency for more information.

Enrollment Criteria

A child from birth up to (but not including) age 3 is eligible for B-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 B-3 information because many children enrolled in the B-3 Program are also BadgerCare Plus members.

Individualized Family Service Plan

A B-3 member receives an IFSP 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 B-3 services must be identified in the child's IFSP.

Requirements for Providers

Title 34 CFR Part 303 for B-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 B-3 services. These children must be referred to the appropriate county B-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 B-3 program for evaluation. (Providers are encouraged to explain the need for the B-3 referral to the child's parents or guardians.)
- Cooperate and participate with B-3 service coordination as indicated in the child's IFSP. B-3 services must be provided by providers who are employed by, or under agreement with, a B-3 agency to provide B-3 services.
- Deliver B-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 certification as a therapy group to be reimbursed for these therapy services.)

- Assist parents or guardians of children receiving B-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.

Services

The B-3 Program covers the following types of services when they are included in the child's IFSP:

- Evaluation and assessment.
- Special instruction.
- OT.
- PT.
- SLP.
- 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

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 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).

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.

Applicant Enrollment Requirements

Applicants are required to apply for the Core Plan and be put on the waitlist before they can enroll in the Basic Plan. The applicant must meet the following program requirements to enroll in the Core Plan and thus qualify for the Core Plan waitlist and the Basic 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. Applicants may be enrolled in Family Planning Only Services or TB-Only).
- Is not eligible for or enrolled in Medicare.
- Has a monthly gross income that does not exceed 200 percent of the FPL.
- Is not covered by health insurance currently or in the previous 12 months unless there is justifiable cause.
- 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 in the Basic Plan must first apply for the Core Plan online or via a toll-free telephone number. A pre-screening tool will help determine which individuals may be eligible to enroll in the Core Plan. Applications for Core Plan members are processed by the ESC, not by county agencies.

Once the Core Plan application process is complete and the individual has been placed on the waitlist for the Core Plan, the individual will have the option to enroll in the Basic Plan. An informational letter will be mailed to individuals on the waitlist with Basic Plan information and a coupon the individual can use to request enrollment in the Basic Plan and submit their initial premium payment. Members of the Basic Plan will be required to pay a monthly premium of approximately $130.00 to maintain coverage. Members who fail to pay the monthly premium will have their Basic Plan coverage terminated and will be subject to a restrictive re-enrollment period, which will not allow the member to re-enroll for 12 months. Termination of Basic Plan coverage does not affect a member's status on the Core Plan waitlist or his or her eligibility for the Core Plan if room becomes available.

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 Standard Plan, the Benchmark Plan, or the Core Plan.
- Becomes incarcerated or becomes institutionalized in an IMD.
- 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, 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 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.

BadgerCare Plus Basic Plan Members Diagnosed with Cancer

Information is available for DOS before January 1, 2011.

BadgerCare Plus Basic Plan members with certain diagnoses may be enrolled in the BadgerCare Plus Core Plan if they meet the Core Plan enrollment rules. If a member has any of the following, they can bypass the Core Plan waitlist and be enrolled in the Core Plan if they meet all of the Core Plan enrollment rules:

- Cancer (except non-melanoma skin cancers).
- Hypertension and high cholesterol combined.
- Atherosclerosis.
- Heart failure.
- Heart disease.

The diagnosis may be a new diagnosis since the member was enrolled in the Basic Plan or it may be a pre-existing condition.

Application Process for Basic Plan Members with Certain Diagnoses

To enroll a Basic Plan member diagnosed with cancer, hypertension and high cholesterol combined, atherosclerosis, heart failure or heart disease in the Core Plan, the provider who has diagnosed the member is required to complete the Core Plan Waitlist — Medical Bypass Determination form. The provider is required to indicate a description of the diagnoses on the form.

Note: Basic Plan members with a diagnosis of one of the non-melanoma skin cancers are not eligible to apply for the Core Plan through the Core Plan waitlist bypass process.

The form must be submitted to the ESC by fax at (888) 415-2115 or by mail to the following address:

Enrollment Services Center
PO Box 7190
Madison WI 53707-7190

Providers are encouraged to submit completed forms by fax to ForwardHealth to avoid delays in mailing of forms.

A copy of the completed Core Plan Waitlist — Medical Bypass Determination should be kept in the member's medical record.

Enrollment Process

After the completed Core Plan Waitlist — Medical Bypass Determination form is received by ForwardHealth, the ESC will verify the information on the form and contact the member to complete the application process via telephone. If the member cannot be reached via telephone, a letter will be mailed to encourage him or her to complete the application process. If the member is eligible for the Core Plan, enrollment will begin on the next first or fifteenth day of the month after the application is approved. The enrollment process is designed to ensure there is no gap in coverage during a member's transition from the Basic Plan to the Core Plan.

If the member does not meet eligibility criteria for the Core Plan, a notice of denial will be mailed to the member and enrollment in the Basic Plan will be terminated since the eligibility criteria for the Core Plan and the Basic Plan are the same.

The usual application processing fee for the Core Plan does not apply to members who have one of the diagnoses and who will transition from the Basic Plan to the Core Plan. The member's most recent premium paid for the Basic Plan is applied as the enrollment fee for the Core Plan.

Members Enrolled in the Wisconsin Well Woman Program and the Basic Plan

Women may be enrolled in the WWWP and the 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 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. If the woman becomes ineligible for WWWMA in the future, she may be eligible to receive benefits from the Basic Plan.

BadgerCare Plus Core Plan

The BadgerCare Plus Core Plan covers basic health care services including primary care, preventive care, certain generic and OTC 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 TB-Only.
- Is not eligible for or enrolled in Medicare.
- Has a monthly gross income that does not exceed 200 percent of the FPL.

- 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

The Core Plan application process will be streamlined and user-friendly. Individuals who wish to enroll may apply for the Core Plan using the Access tool online or via the ESC. 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-certified providers cannot pay the $60.00 application processing fee on behalf of Core Plan applicants. An offer by a Medicaid-certified 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 and the Department of HHS's OIG.

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.
- 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 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, 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 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.

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

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. 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 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.

Express Enrollment for Children and Pregnant Women

EE 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.

To determine enrollment for EE for Pregnant Women, providers should use the income limits for 200 percent and 300 percent of the FPL.

The EE for Children Benefit allows certain members under 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.

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 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, 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 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.

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.

ForwardHealth and ForwardHealth interChange

ForwardHealth brings together many DHS health care programs with the goal to create efficiencies for providers and to improve health outcomes for members. ForwardHealth interChange is the DHS claims processing system that supports multiple state health care programs and Web services, including:

- BadgerCare Plus.
- BadgerCare Plus and Medicaid managed care programs.
- SeniorCare.
- WCDP.
- WIR.
- Wisconsin Medicaid.
- Wisconsin Well Woman Medicaid.
- WWWP.

ForwardHealth interChange is supported by the state's fiscal agent, HP.

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 for Children.
- EE for Pregnant Women.
- Family Planning Only Services, including TE for Family Planning Only Services.
- QDWI.
- QI-1.

- QMB Only.
- SLMB.
- TB-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 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.

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, MA, 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.
- WWWP.

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 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.

Qualified Disabled Working Individual Members

QDWI 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.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.
- Have income or assets too high to qualify for QMB Only and SLMB.

Qualified Medicare Beneficiary-Only Members

QMB-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.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Qualifying Individual 1 Members

QI-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.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Specified Low-Income Medicare Beneficiaries

SLMB 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.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Tuberculosis-Related Services-Only Benefit

The TB-Only Benefit is a limited benefit category that allows individuals with TB infection or disease to receive covered TB-related outpatient services.

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 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 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 for Adults with No Dependent Children are eligible to be enrolled in Wisconsin Well Woman Medicaid. 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-certified 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. 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.

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.

Wisconsin Well Woman Medicaid Enrollment from the Benchmark Plan or the Core Plan

To enroll a woman to 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 form, F-10075 (07/06). The form may be obtained from the Wisconsin Department of Health Services at dhs.wisconsin.gov./forms/.

The form should be faxed to the Central Application Processing Operation (CAPO) at (608) 267-3381 or sent via e-mail 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 Portalor on 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

General Information

Members have certain responsibilities per DHS 104.02, Wis. Admin. Code, and the ForwardHealth Enrollment and Benefits booklet.

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 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 or the ForwardHealth Portal prior to providing each service, even if an approved PA request is obtained for the service.

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.

Members Should Present Card

It is important that providers determine a member's enrollment and other insurance coverage *prior to* each DOS 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 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.

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.

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

Appealing Enrollment Determinations

Applicants and members have the right to appeal certain decisions relating to BadgerCare Plus or Medicaid enrollment. An applicant, a member, or authorized person acting on behalf of the applicant or member, or former member may file the appeal with the DHA.

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

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

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

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

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

Claims for Appeal Reversals

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

ForwardHealth
Specialized Research
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

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.

Freedom of Choice

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

General Information

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

Notification of Discontinued Benefits

When the DHS 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.

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.

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 members.

Identification Cards

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 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.

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 the ESC with questions about enrollment criteria, HMO enrollment, and covered services. The ForwardHealth Core Plan cards include the Enrollment Services Center telephone number, (800) 291-2002, on the back.

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.

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.

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.

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 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.

Temporary Enrollment for Family Planning Only Services Identification Cards

Qualified providers may issue white paper TE for Family Planning Only Services identification cards for women to use temporarily until they receive a ForwardHealth identification card. The identification card is included with the TE for Family Planning Only Services Application.

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.

Temporary Express Enrollment Cards

There are two types of temporary EE 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 (formerly known as PE) 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. The beige paper identification card is attached to the last page of the application and provided to the woman after she completes the enrollment process. A sample of an EE temporary card from the back of the EE application is available.

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 to verify enrollment for DOS after those printed on the card. Providers are encouraged to keep a photocopy of the card.

Temporary ForwardHealth Identification Cards

All Medicaid certifying agencies have the authority to issue green paper temporary identification cards to applicants who meet enrollment requirements. Temporary cards are usually issued only when an applicant is in need of medical services prior to receiving the ForwardHealth card. Providers should accept temporary cards as proof of enrollment. Eligible applicants may receive covered services for the dates shown on the card.

Providers are encouraged to keep a photocopy of the temporary card and should delay submitting claims for one week from the enrollment start date until the enrollment information is transmitted to ForwardHealth.

ForwardHealth accepts properly completed and submitted claims for covered services provided to applicants possessing a temporary card as long as the DOS is within the dates shown on the card.

If a claim is denied with an enrollment-related explanation, even though the provider verified the member's enrollment before providing the service, a good faith claim may be submitted.

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.
- Green paper temporary cards.
- Paper printout temporary card for EE for children.
- Paper printout temporary card for EE for pregnant women.
- Beige paper temporary card for EE for pregnant women.
- White paper TE for Family Planning Only Services cards.

Misuse and Abuse of Benefits

Examples of Member Abuse or Misuse

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

Notifying ForwardHealth

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. 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 doing so. A provider may not confiscate a ForwardHealth card from a member in question.

If a provider suspects that a member is abusing his or her benefits or misusing his or her ForwardHealth card, providers are required to notify ForwardHealth by calling Provider Services or by writing to the following office:

Division of Health Care Access and Accountability
Bureau of Program Integrity
PO Box 309
Madison WI 53701-0309

ForwardHealth monitors member records and can impose sanctions on those who misuse or abuse their benefits. For more information on member misuse and abuse and the resulting sanctions, refer to s. 49.49, Wis. Stats.

Pharmacy Services Lock-In Program

Information for DOS on and after April 1, 2011, is available.

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 prescriptions for controlled substances.

Coordination of member health care services is intended to do the following:

- 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 controlled substance medications. Abuse or misuse is defined under Recipient Duties in DHS 104.02(5), Wis. Admin. Code. The abuse and misuse definition includes, but is not limited to, the following:

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

Members enrolled in the Pharmacy Services Lock-In Program are assigned to one primary care provider and one pharmacy to reduce unnecessary physician and pharmacy utilization and to discourage the non-medical or excessive use of prescription drugs.

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

HID administers the Pharmacy Services Lock-In Program. Providers may contact the Pharmacy Services Lock-In Program by calling (800) 225-6998, extension 3045.

Reporting Suspected Member Misuse of Benefits

ForwardHealth operates a therapeutic DUR program designed to routinely monitor prescription drug use by members. The purpose of the DUR program is to identify potential clinical problems related to drug therapy and instances of potentially inappropriate drug use. When a member is identified through the DUR Program of suspected misuse of benefits, the member and the member's primary care provider(s) and pharmacy(s) may be notified.

Providers may also report members suspected of inappropriate prescription drug use by completing the Pharmacy Services Lock-In Program Request for Review of Member Prescription Drug Use form and submitting the form to the Pharmacy Services Lock-In Program. When a provider refers a member for review, the Lock-In Program assesses the member's history of prescription drug claims to identify patterns that suggest possible misuse of prescription drugs.

The Pharmacy Services Lock-In Program monitors claims for pharmacy services and prescription drugs specifically. The Pharmacy Services Lock-In Program does not address other types of member fraud or misuse of benefits, such as misuse of the ForwardHealth identification card or excessive use of emergency room services.

Designated Lock-In Pharmacy and Primary Care Provider

Members enrolled in the Pharmacy Services Lock-In Program are required to designate one Lock-In pharmacy and one Lock-In primary care provider. If the member fails to designate Lock-In providers, ForwardHealth or the member's HMO choose for the member. During the member's enrollment in the Lock-In Program, the member may only receive services from the Lock-In primary care provider and the Lock-In pharmacy unless a referral is in place for another provider.

Fee-for-service members are assigned to one pharmacy and one primary care provider.

Members enrolled in an HMO are assigned to one pharmacy. The HMO is assigned as the member's designated Lock-In primary care provider. The HMO may in turn assign the member to one of the HMO's primary care providers.

Role of the Lock-In Pharmacy and Primary Care Provider

The Lock-In pharmacy fills prescriptions that are medically necessary for the member and works with the Lock-In primary care provider or HMO to ensure the member's drug regimen is consistent with the overall care plan. The Lock-In pharmacy may fill prescriptions from prescribers other than the Lock-In primary care provider, but the Lock-In pharmacy must assure that prescriptions are medically necessary, are consistent with the care plan, and are not overlapping with other similar medications. If the member presents a prescription from an emergency room visit, the pharmacist at the Lock-In pharmacy must use his or her professional judgment as to whether or not to fill the prescription.

The Lock-In primary care provider determines what services are medically necessary for the member, provides those services at his or her discretion, and refers the member to other providers if needed. The Lock-In primary care provider also may contact the Lock-In pharmacy to give the pharmacist(s) guidelines as to which medications should be filled for the member and from whom.

Changing the Designated Lock-In Provider

If circumstances arise that require a change to the member's designated Lock-In pharmacy or primary care provider, contact the Pharmacy Services Lock-In Program at (800) 225-6998, extension 3045. Providers should allow at least one business day for the change to be applied to the member's file.

Referrals for Members Enrolled in the Pharmacy Services Lock-In Program

For all non-emergency, medically necessary, non-pharmacy services, the member's designated Lock-In primary care provider may perform the service or refer the member to another provider, as necessary. The member's Lock-In pharmacy may refer the member to other pharmacies to fill prescriptions if needed.

Referrals to other providers must be on file with the Pharmacy Services Lock-In Program before the member may receive services from any provider other than the designated Lock-In primary care provider or pharmacy. Services provided by providers other than the member's designated Lock-In primary care provider or pharmacy are not reimbursable unless a referral is on file with ForwardHealth.

If the member requires a referral, the Lock-In provider 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 Services Lock-In Program and the member's HMO.

Note: Emergency medical care is the only exception to the referral requirement.

Looking Up Referral Providers on the ForwardHealth Portal

ForwardHealth Portal member enrollment verification indicates a member's referral providers under the Pharmacy Services Lock-In Program. When a provider looks up member enrollment information, the Portal lists the member's Lock-In pharmacy, Lock-In primary care provider (when applicable), and referral providers.

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.

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

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.

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 covers 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 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 certified 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.

Newborn Reporting

Hospitals, physicians, nurse practitioners, nurse midwives, and BadgerCare Plus or Medicaid HMOs may submit Newborn Report forms to report babies born to BadgerCare Plus and Medicaid members.

Physicians, nurse practitioners, and nurse midwives should submit a Newborn Report *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 completes the form. 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.

Hospital providers or HMOs should complete and submit *one* Newborn Report form for a 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 submit the form. Providers should not submit duplicate forms.

The Newborn Report form should be submitted 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 mom after birth.

If the mother was *not* covered by Wisconsin Medicaid when the baby was born, she can apply for benefits retroactively. If her dates of enrollment include the date of the baby's birth, her baby can also receive retroactive and continuous enrollment for the first year of life.

Newborn Report Submission

ForwardHealth no longer accepts newborn reports from providers that list multiple babies. Instead, one Newborn Report must be

completed and submitted to ForwardHealth for each baby born to a woman enrolled in BadgerCare Plus or Medicaid.

Providers are encouraged to submit a Newborn Report form soon after a baby is born to avoid a delay in establishing the baby's enrollment in BadgerCare Plus or into the mother's BadgerCare Plus HMO. Reporting newborns is not mandatory; however, providers are required to complete the Newborn Report form if newborns are reported to ForwardHealth.

Newborn Report forms 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, Newborn Report forms *cannot* be submitted via e-mail.

Newborn Report forms should be submitted only for babies born to women enrolled in BadgerCare Plus or Medicaid. Newborns may be enrolled through the EE process only if the mother is *not* enrolled in BadgerCare Plus or Medicaid at the time of birth. The mother may also apply for eligibility for her baby through her certifying agency.

Indicate a Name on Newborn Reports

Providers are required to indicate a baby's name on Newborn Report forms. The baby's name is required to prevent delays in establishing member enrollment and to avoid assigning multiple ID numbers for the baby. Other versions of the Newborn Report form or forms submitted with a name other than the baby's name (e.g., Boy Smith) will be returned to providers unprocessed, with the following exceptions:

- If a baby is being adopted or entering foster care and has not received a name yet.
- If the baby has not received a name due to religious or cultural reasons.

Forms will be returned in the manner in which they were submitted and to the contact person indicated on the Newborn Report.

Providers are required to check the box on the Newborn Report form that indicates why the baby has not received a name.

Note: Providers should indicate a note saying "Actual Name" in the Name — Newborn field on the form when a baby's name is actually "Baby," "Boy," "Girl," or a similar type of permanent name.

Newborn Report Procedures

Once the completed Newborn Report is submitted, the following procedures take place:

- A ForwardHealth identification number is assigned to the newborn, if they do not have an existing ID number on file. If the baby is reported without a permanent name, the form will be returned to the reporting provider.
- A ForwardHealth card is issued to the child as soon as the child's enrollment is put on file.
- A letter is sent to the mother, notifying her of the child's enrollment.

Providers with questions regarding newborn enrollment or the Newborn Report may call Provider Services.

Non-U.S. Citizens — Emergency Services

Certain non-U.S. citizens who are not qualified aliens are eligible for BadgerCare Plus services only in cases of acute emergency medical conditions. Providers should use the appropriate ICD-9-CM 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 does 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 option. However, babies born to women with incomes over 300 percent of the FPL are not eligible for CEN status. The baby may still qualify for BadgerCare Plus. These mothers should report the birth to the local agencies within ten calendar days.

A provider who gives emergency care to a non-U.S. citizen should refer him or her to the local county or tribal agency or ForwardHealth outstation site for a determination of BadgerCare Plus enrollment. Providers may complete the Certification of Emergency for Non-U.S. Citizens 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.

Out-of-State Youth Program

The OSY program is responsible for health care services provided to Wisconsin children placed outside the state in foster and subsidized adoption situations. These children are eligible for coverage. The objective is to assure that these children receive quality medical care.

Out-of-state providers not located in border-status-eligible communities may qualify as border-status providers if they deliver services as part of the OSY program. However, providers who have border status as part of the OSY program are reimbursed only for services provided to the specific foster care or subsidized adopted child. In order to receive reimbursement for services provided to other members, the provider is required to follow rules for out-of-state noncertified providers.

For subsidized adoptions, benefits are usually determined through the adoption assistance agreement and are provided by the state where the child lives. However, some states will not provide coverage to children with state-only funded adoption assistance. In these cases, Wisconsin will continue to provide coverage.

OSY providers are subject to the same regulations and policies as other certified border-status providers. For more information about the OSY program, call Provider Services or write to ForwardHealth at the following address:

ForwardHealth
Out-of-State Youth
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

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.

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-certified provider for a covered service during the period of retroactive enrollment, according to DHS 104.01(11), Wis. Admin. Code. A Medicaid-certified 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 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 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 (if the services provided during the period of retroactive enrollment were covered).

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*. 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 and write "RETROACTIVE ENROLLMENT" on the PA/RF.
- *Was a sterilization procedure*. If the provider performed a sterilization procedure before the member was enrolled and the provider has met all federal regulations regarding the required Sterilization Informed Consent form, then a claim may be submitted for the sterilization. If the member did not sign the consent form at least 30 days prior to the procedure, the provider will not receive reimbursement.
- *Was a hysterectomy procedure*. If the member underwent a hysterectomy, the hysterectomy may be reimbursed if the provider attests in a signed, written statement attached to the 1500 Health Insurance Claim Form paper claim 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.

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 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 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:03/01/2011

Prior Authorization:Advanced Imaging Services

Prior Authorization for Advanced Imaging Services

Most advanced imaging services, including CT, MR, and PET imaging, require PA when performed in either outpatient hospital settings or in non-hospital settings (e.g., radiology clinics). MedSolutions, a private radiology benefits manager, is authorized to administer PA for advanced imaging services on behalf of ForwardHealth. Refer to the Prior Authorization section of the Radiology area of the Online Handbook for PA requirements and submission information for advanced imaging services.

Decisions

Approved Requests

PA 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.

Communicating Prior Authorization Decisions

ForwardHealth will make a decision regarding a provider's PA 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.

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 request or amendment request via the Portal to ForwardHealth for processing.

Decision Notice Letters and Returned Provider Review Letters on the Portal

Providers can view PA 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.

Denied Requests

When a PA 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, PA/DRF, or PA/HIAS1.
- 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.

Modified Requests

Modification is a change in the services originally requested on a PA 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.

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 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.

Returned Requests

A PA 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, photographs, and dental molds will be returned once the PA is finalized for dentists, physicians, and DME providers. 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

Emergency Services

In emergency situations, the PA 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.

Urgent Services

Telephone consultations with DHCAA staff regarding a prospective PA 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 DHCAA's Bureau of Program Integrity 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

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. If the provider submitted the amendment request via the ForwardHealth Portal, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal.

If the provider submitted an amendment request 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 provider submitted a paper amendment request via mail or fax and does not have a Portal account, the decision notice letter or returned amendment 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 amendment request.

Neither the decision notice letter nor the returned amendment provider review letter will be faxed back to providers who submitted their paper amendment request via fax. Providers who submitted their paper amendment request via fax will receive the decision notice letter or returned amendment provider review letter via mail.

Amendments

Providers are required to use the Prior Authorization Amendment Request to amend an approved or modified PA 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 ForwardHealth Member 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.

Appeals

If a PA 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. 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 letter.

To file an appeal, members may complete and submit a Request for Fair Hearing 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
6406 Bridge Rd
Madison WI 53784-0050

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
6406 Bridge Rd
Madison WI 53784-0088

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.

Enddating

Providers are required to use the Prior Authorization Amendment Request to enddate most PA 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 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.

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 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, photographs, and dental models will be returned once the amendment request is finalized for dentists, physicians, and DME providers. 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.

Searching for Previously Submitted Prior Authorization

Requests on the Portal

Providers will be able to search for all previously submitted PA 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

An Overview

Depending on the service being requested, most PA requests must be comprised of the following:

- The PA/RF, PA/DRF, or PA/HIAS1.
- A service-specific PA attachment(s).
- Additional supporting clinical documentation.

Attachments

In addition to the PA/RF, PA/HIAS1, or PA/DRF, a service-specific PA 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.

Prior Authorization/Physician Attachment

The PA/PA 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 is to document the medical necessity of physician-administered drugs requiring PA.

Prior Authorization/Physician Otological Report

Completion of the PA/POR 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-certified hearing instrument specialist to receive a hearing aid.

Obtaining Forms and Attachments

Providers may obtain paper versions of all PA 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
6406 Bridge Rd

Madison WI 53784-0003

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 and fillable Microsoft® Word formats.

Web Prior Authorization Via the Portal

Certain providers may complete the PA/RF 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.

Prior Authorization Request Form

The PA/RF is used by ForwardHealth and is mandatory for most providers when requesting PA. 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 claim for prior authorized services.

Prior Authorization Request Form Completion Instructions for Physician Services

A sample PA/RF 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 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, the PA/JCA, and the Prior Authorization Drug Attachment for Synagis by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

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 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 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.

SECTION II — MEMBER INFORMATION

Element 6 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or Wisconsin's EVS to obtain the correct number.

Element 7 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

Element 8 — Address — Member
Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code. If the member is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 9 — Name — Member
Enter the member's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 10 — Gender — Member
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 11 — Diagnosis — Primary Code and Description
Enter the appropriate ICD-9-CM diagnosis code and description most relevant to the service/procedure requested.

Element 12 — Start Date — SOI (not required)

Element 13 — First Date of Treatment — SOI (not required)

Element 14 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Element 15 — Requested PA Start Date
Enter the requested start date for service(s) in MM/DD/CCYY format, if a specific start date is requested.

Element 16 — Rendering Provider Number
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 17 — 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 18 — Procedure Code
Enter the appropriate CPT code or HCPCS code for each service/procedure/item requested.

Element 19 — Modifiers
Enter the modifier(s) corresponding to the procedure code listed if a modifier is required.

Element 20 — POS
Enter the appropriate POS code designating where the requested service/procedure/item would be provided/performed/dispensed.

Element 21 — Description of Service
Enter a written description corresponding to the appropriate CPT code or HCPCS code for each service/procedure/item requested.

Element 22 — QR
Enter the appropriate quantity (e.g., number of services, days' supply) requested for the procedure code listed.

Element 23 — Charge
Enter the provider's usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to provider *Terms of Reimbursement* issued by the DHS.

Element 24 — Total Charges
Enter the anticipated total charges for this request.

Element 25 — Signature — Requesting Provider
The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 26 — Date Signed
Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

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 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 by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

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 if the services requested on the PA/RF are for a WCDP member.

Element 2 — Process Type

Enter process type 131 — Drugs. 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.

Note: Prescribers who are certified by Wisconsin Medicaid should indicate their name and address as the billing provider on PA requests. Prescribers who are not certified by Wisconsin Medicaid should indicate the name and address of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

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.

Note: Prescribers who are certified by Wisconsin Medicaid should indicate their name and address as the billing provider on PA requests. Prescribers who are not certified by Wisconsin Medicaid should indicate the name and address of the Wisconsin Medicaid-

certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

Element 5a — Billing Provider Number

Enter the NPI of the billing provider. The NPI in this element must correspond with the provider name listed in Element 4.

Note: Prescribers who are certified by Wisconsin Medicaid should indicate their name and address as the billing provider on PA requests. Prescribers who are not certified by Wisconsin Medicaid should indicate the name and address of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

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.

Note: Prescribers who are certified by Wisconsin Medicaid should indicate their name and address as the billing provider on PA requests. Prescribers who are not certified by Wisconsin Medicaid should indicate the name and address of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

SECTION II — MEMBER INFORMATION

Element 6 — Member Identification Number

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

Element 7 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

Element 8 — Address — Member

Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code. If the member is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 9 — Name — Member

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

Element 10 — Gender — Member

Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 11 — Diagnosis — Primary Code and Description

Enter the appropriate ICD-9-CM diagnosis code and description most relevant to the service/procedure requested.

Element 12 — Start Date — SOI (not required)

Element 13 — First Date of Treatment — SOI (not required)

Element 14 — Diagnosis — Secondary Code and Description

Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Element 15 — Requested PA Start Date

Enter the requested start DOS in MM/DD/CCYY format.

Element 16 — 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 17 — 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 18 — Procedure Code (not required)

Element 19 — Modifiers (not required)

Element 20 — POS

Enter the NCPDP patient location code of "0" (Not Specified).

Element 21 — Description of Service

Enter the drug name and dose for each item requested (e.g., drug name, milligrams, capsules).

Element 22 — QR

Enter the appropriate quantity (e.g., days' supply) requested for each item requested.

Element 23 — Charge (not required)

Element 24 — Total Charges (not required)

Element 25 — Signature — Requesting Provider

The original signature of the provider requesting this item must appear in this element.

Element 26 — Date Signed

Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

Supporting Clinical Documentation

Certain PA 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 photographs will be returned to providers with the finalized PA request. X-rays and photographs must be mailed with the PA request. Mailing dental models with PA requests is recommended.

General Information

An Overview

The PA review process continues to include 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.

Communication with Members

ForwardHealth recommends that providers inform members that PA 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.

Definition

PA 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.

Designating an Address for Prior Authorization Correspondence

Correspondence related to PA 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 photographs.

Providers who want to designate a separate address for PA correspondence have the following options:

- Update demographic information online via the ForwardHealth Portal. (This option is only available to providers who have established a provider account on the Portal.)
- Submit a Provider Change of Address or Status form.

Prior Authorization Numbers

Upon receipt of the PA/RF, ForwardHealth will assign a PA 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; 4 = STAT-PA; 5 = Portal; 6 = Portal; 7 = NCPDP transaction
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.

Reasons for Prior Authorization

Only about four percent of all services covered by Wisconsin Medicaid require PA. 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.

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.

Referrals to Out-of-State Providers

PA may be granted to non-certified out-of-state providers when nonemergency services are necessary to help a member attain or regain his or her health and ability to function independently. The PA request may be approved only when the services are not reasonably accessible to the member in Wisconsin.

Out-of-state providers are required to meet Wisconsin Medicaid's guidelines for PA approval. This includes sending PA requests, required attachments, and supporting documentation to ForwardHealth before the services are provided.

Note: Emergency services provided out-of-state do not require PA; however, claims for such services must include appropriate documentation (e.g., anesthesia report, medical record) to be considered for reimbursement. Providers are required to submit claims with supporting documentation on paper.

When a Wisconsin Medicaid provider refers a member to an out-of-state, non-certified provider, the referring provider should refer the out-of-state provider to the ForwardHealth Portal or Provider Services to obtain appropriate certification materials, PA forms, and claim instructions.

All out-of-state nursing homes, regardless of location, are required to obtain PA for all services. All other out-of-state non-border-status providers are required to obtain PA for all nonemergency services except for home dialysis supplies and equipment.

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 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 certified by 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.

Sources of Information

Providers should verify that they have the most current sources of information regarding PA. 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.

Status Inquiries

Providers may inquire about the status of a PA request through one of the following methods:

- Accessing WiCall, ForwardHealth's AVR system.
- Calling Provider Services.

Providers should have the 10-digit PA number available when making inquiries.

Grant and Expiration Dates

Backdating

Backdating an initial PA request or SOI 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.

Expiration Date

The expiration (end) date of an approved or modified PA 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.

Grant Date

The grant (start) date of an approved or modified PA 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.

Renewal Requests

To prevent a lapse in coverage or reimbursement for ongoing services, all renewal PA 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

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 before the services are provided at each visit.
- When the PA 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.

Retroactive Disenrollment from State-Contracted MCOs

Occasionally, a service requiring fee-for-service PA is performed during a member's enrollment period in a state-contracted MCO. 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. 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.

Retroactive Enrollment

If a service(s) that requires PA was performed during a member's retroactive enrollment period, the provider is required to submit a PA request and receive approval from ForwardHealth *before* submitting a claim. For a PA request submitted on paper, indicate the words "RETROACTIVE ENROLLMENT" at the top of the PA request along with a written description explaining that the service was provided at a time when the member was retroactively enrolled under "Description of Service." Also include the actual date(s) the service(s) was provided. For a PA request submitted via the ForwardHealth Portal, indicate the words "RETROACTIVE ENROLLMENT" along with a description explaining that the service was provided at a time when the member was retroactively eligible under the "Service Code Description" field or include additional supporting documentation. Also include the actual date(s) the service(s) was provided.

If the member was retroactively enrolled, and the PA request is approved, the service(s) may be reimbursable, and the earliest effective date of the PA request will be the date the member receives retroactive enrollment. If the PA request is denied, the provider will not be reimbursed for the service(s). Members have the right to appeal the decision to deny a PA request.

If a member requests a service that requires PA before his or her retroactive enrollment is determined, the provider should explain to the member that he or she may be liable for the full cost of the service if retroactive enrollment is not granted and the PA request is not approved. This should be documented in the member's record.

Review Process

Clerical Review

The first step of the PA request review process is the clerical review. The provider, member, diagnosis, and treatment information indicated on the PA/RF, PA/HIAS1, and PA/DRF 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 certified.
- 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.

Clinical Review

Upon verifying the completeness and accuracy of clerical items, the PA 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. HFS 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.
- Standards of practice.
- Professional knowledge.
- Scientific literature.

Services Requiring Prior Authorization

An Overview

Physician services that require PA 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 certification 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-certified pharmacist or Provider Services for information regarding possible PA or diagnosis restrictions for a particular drug.

Audiological Testing for Hearing Instruments

A PA/POR 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 recipient who presents it to the Medicaid-certified audiologist or hearing instrument specialist of his or her choice.

Dermabrasion

PA requests for dermabrasion (procedure codes 15780-15783) will not be approved if the purpose is tattoo removal.

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.

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.

Organ Transplants

The hospital, rather than the physician, is responsible for obtaining PA for these services. 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.

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.

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.

Weight Management Services

All medical services (beyond five E&M office visits per calendar year) aimed specifically at weight management and procedures to reverse such services require PA.

Codes

The following physician-related procedure codes require PA. This list is subject to change and is periodically updated by Wisconsin Medicaid.

Category	Procedure Code	Description
Drugs Administered Other than Oral Method	J0256	Injection, alpha 1 - proteinase inhibitor - human, 10 mg
	J0270	Injection, alprostadil, per 1.25 mcg
	J0725	Injection, chorionic gonadotropin, per 1,000 USP units
	J2760	Injection, phentolamine mesylate (Regitine), up to 5 mg
	J3490*	Unclassified drugs
Q Codes (Temporary)	Q2014	Injection, sermorelin acetate, 0.5 mg
Temporary National Codes (Non-Medicare)	S1040	Cranial remolding orthosis, rigid, with soft interface, material, custom fabricated, includes fitting and adjustment(s)
	S2053	Transplantation of small intestine and liver allografts
	S2054	Transplantation of multivisceral organs
	S2055	Harvesting of donor multivisceral organs, with preparation and maintenance of allografts; from cadaver donor
Integumentary System	11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
	11951	1.1 to 5.0 cc
	11952	5.1 to 10.0 cc
	11954	over 10.0 cc
	11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
	11970	Replacement of tissue expander with permanent prosthesis
	15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)

15781	segmental, face
15782	regional, other than face
15783	superficial, any site (eg, tattoo removal)
15820	Blepharoplasty, lower eyelid;
15821	with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid;
15823	with excessive skin weighting down lid
15824	Rhytidectomy; forehead
15825	neck with platysmal tightening (platysmal flap, P-flap)
15826	glabellar frown lines
15828	cheek, chin, and neck
15829	superficial musculoaponeurotic system (SMAS) flap
15831	Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty)
15832	thigh
15833	leg
15834	hip
15835	buttock
15836	arm
15837	forearm or hand
15838	submental fat pad
15839	other area
19140	Mastectomy for gynecomastia
19316**	Mastopexy
19318**	Reduction mammaplasty
19324**	Mammaplasty, augmentation; without prosthetic implant
19325**	with prosthetic implant
19340**	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342**	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350**	Nipple/areola reconstruction
19357**	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
19361**	Breast reconstruction with latissimus dorsi flap, with or without prosthetic implant
19364**	Breast reconstruction with free flap
19366**	Breast reconstruction with other technique
19367**	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;
19368**	with microvascular anastomosis (supercharging)
19369**	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site

	19380**	Revision of reconstructed breast
	19396**	Preparation of moulage for custom breast implant
Musculoskeletal System	21010	Arthrotomy, temporomandibular joint
	21050	Condylectomy, temporomandibular joint (separate procedure)
	21060	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)
	21070	Coronoidectomy (separate procedure)
	21073	Manipulation of TMJ, therapeutic, requiring an anesthesia service (i.e., general or monitored anesthesia care)
	21079	Impression and custom preparation; interim obturator prosthesis
	21080	definitive obturator prosthesis
	21081	mandibular resection prosthesis
	21082	palatal augmentation prosthesis
	21083	palatal lift prosthesis
	21084	speech aid prosthesis
	21085	oral surgical splint
	21086	auricular prosthesis
	21087	nasal prosthesis
	21088	facial prosthesis
	21089	Unlisted maxillofacial prosthetic procedure
	21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
	21121	sliding osteotomy, single piece
	21122	sliding osteotomies, two or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
	21123	sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
	21125	Augmentation, mandibular body or angle; prosthetic material
	21127	with bone graft, onlay or interpositional (includes obtaining autograft)
	21137	Reduction forehead; contouring only
	21138	contouring and application of prosthetic material or bone graft (includes obtaining autograft)
	21139	contouring and setback of anterior frontal sinus wall
	21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft
	21142	two pieces, segment movement in any direction, without bone graft
	21143	three or more pieces, segment movement in any direction, without bone graft
	21145	single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
	21146	two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)
	21147	three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)

21150	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)
21151	any direction, requiring bone grafts (includes obtaining autografts)
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autographs); without LeFort I
21155	with LeFort I
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I
21160	with LeFort I
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180	with autograft (includes obtaining grafts)
21181	Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm
21183	total area of bone grafting greater than 40 sq cm but less than 80 sq cm
21184	total area of bone grafting greater than 80 sq cm
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
21194	with bone graft (includes obtaining graft)
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
21196	with internal rigid fixation
21198	Osteotomy, mandible, segmental
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21215	mandible (includes obtaining graft)
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
21235	ear cartilage, autogenous, to nose or ear (includes obtaining graft)
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes

		obtaining graft)
	21242	Arthroplasty, temporomandibular joint, with allograft
Musculoskeletal System (Continued)	21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement
	21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)
	21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial
	21246	complete
	21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)
	21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial
	21249	complete
	21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
	21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)
	21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach
	21261	combined intra- and extracranial approach
	21263	with forehead advancement
	21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach
	21268	combined intra- and extracranial approach
	21270	Malar augmentation, prosthetic material
	21275	Secondary revision of orbitocraniofacial reconstruction
	21280	Medial canthopexy (separate procedure)
	21282	Lateral canthopexy
	21295	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach
	21296	intraoral approach
	21299	Unlisted craniofacial and maxillofacial procedure
	21740	Reconstructive repair of pectus excavatum or carinatum; open
Respiratory System	30120	Excision or surgical planing of skin of nose for rhinophyma
	30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
	30410	complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
	30420	including major septal repair
	30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
	30435	intermediate revision (bony work with osteotomies)
	30450	major revision (nasal tip work and osteotomies)
	32851	Lung transplant, single; without cardiopulmonary bypass [transplant center obtains PA, **not** physician]
	32852	with cardiopulmonary bypass [transplant center obtains PA, **not** physician]
	32853	Lung transplant, double (bilateral sequential or en bloc); without

		cardiopulmonary bypass [transplant center obtains PA, **not** physician]
	32854	with cardiopulmonary bypass [transplant center obtains PA, **not** physician]
Cardiovascular System	33935	Heart-lung transplant with recipient cardiectomy-pneumonectomy [transplant center obtains PA, **not** physician]
	33945	Heart transplant, with or without recipient cardiectomy [transplant center obtains PA, **not** physician]
	37650	Ligation of femoral vein
Hemic and Lymphatic System	38240	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic [transplant center obtains PA, **not** physician]
	38241	autologous [transplant center obtains PA, **not** physician]
Digestive System	42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)
	42950	Pharyngolplasty (plastic or reconstructive operation on pharynx)
	43644	Laparascopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (Roux limb 150 cm or less)
	43645	with gastric bypass and small intestine reconstruction to limit absorption
	43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
	43843	other than vertical-banded gastroplasty
	43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 100 cm) Roux-en-Y gastroenterostomy
	43847	with small intestine reconstruction to limit absorption
	43848	Revision of gastric restrictive procedure for morbid obesity (separate procedure)
	44135	Intestinal allotransplantation; from cadaver donor
	44136	from living donor
	44137	Removal of transplanted intestinal allograft, complete
	47135	Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age [transplant center obtains PA, **not** physician]
	47136	heterotopic, partial or whole, from cadaver or living donor, any age [transplant center obtains PA, **not** physician]
	47399	Unlisted procedure, liver (PA required only for liver-small intestine transplant) [transplant center obtains PA, **not** physician]
	48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells [transplant center obtains PA, **not** physician]
	48554	Transplantation of pancreatic allograft [transplant center obtains PA, **not** physician]
Male Genital System	54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
	54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
	54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
Female Genital System	57291	Construction of artificial vagina; without graft
	57292	with graft
	58400	Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; (separate procedure)

	58410	with presacral sympathectomy
Nervous System	61490	Craniotomy for lobotomy, including cingulotomy
	61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
	64573	Incision for implantation of neurostimulator electrodes; cranial nerve
Eye and Ocular Adnexa	67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
	67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material
	67902	frontalis muscle technique with fascial sling (includes obtaining fascia)
	67903	(tarso) levator resection or advancement, internal approach
	67904	(tarso) levator resection or advancement, external approach
	67906	superior rectus technique with fascial sling (includes obtaining fascia)
	67908	conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)
	67909	Reduction of overcorrection of ptosis
Auditory System	69714	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
	69715	with mastoidectomy
	69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
	69718	with mastoidectomy
	69930	Cochlear device implantation, with or without mastoidectomy
Special Otorhinolaryngologic Services	92510	Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming

*Requires PA only when drug may also be used as a fertility drug.

**Does not require PA if diagnosis is breast cancer (ICD-9-CM diagnosis codes 174.0-174.9, 175.0-175.9, 233.0, 238.3, 239.3).

Prior Authorization Requests and Amendments for Synagis

Synagis® requires PA. 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.

Prescribers or their designees must request PA for Synagis® using only one of the following options:

- DAPO Center.
- 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 for physician services.
- Prior Authorization Drug Attachment for Synagis.
- Supporting documentation, as appropriate.

The Prior Authorization Fax Cover Sheet is available for providers submitting the forms and documentation by fax.

Prior Authorization Amendments

If a member's weight changes, resulting in a change in Synagis® dosage during a treatment season, prescribers are required to amend an approved PA for the appropriate dose. PA requests may be amended through the following:

- By calling the DAPO Center.
- On the Portal.
- By submitting a Prior Authorization Amendment Request to ForwardHealth by mail or fax.

Prescribers are required to indicate the following on PA amendment requests for Synagis®:

- The member's most recent weight.
- The date the member's weight was measured.
- The new Synagis® dose calculation.

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 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 or advanced AIDS). 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 the following risk factors:
    - The member is less than 3 months of age at the start of the RSV season or is born during the RSV season with 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.

Prior Authorization for Anti-Obesity Drugs

PA requests for the following anti-obesity drugs may be submitted on the Prior Authorization Drug Attachment for Anti-Obesity Drugs:

- Diethylpropion.
- Phentermine.
- Phendimetrazine.
- Xenical.

Note: Anti-obesity drugs are not covered by the BadgerCare Plus Benchmark Plan or the BadgerCare Plus Core Plan.

Anti-obesity drugs are covered for dual eligibles enrolled in a Medicare Part D PDP.

A 34-day supply is the maximum amount of any anti-obesity drug that may be dispensed each month.

Clinical Criteria

Clinical criteria for approval of a PA request for anti-obesity drugs require one of the following:

- The member has a BMI 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 member does not have a medical contraindication to the selected medication.
- 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 drug if an FDA-approved generic equivalent is available. In addition, ForwardHealth does not cover OTC anti-obesity drugs. ForwardHealth will return PA requests for OTC and brand name anti-obesity drugs with generic equivalents as noncovered services.

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 three months. If the member meets a weight loss goal of at least 10 pounds 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 during the initial three month approval, the member must wait six months before PA is requested for any 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.

Xenical®

If clinical criteria are met, initial PA requests for Xenical® (orlistat) will be approved for six months. If the member does not meet a weight loss goal of at least 10 pounds during the initial six-month approval, the member must wait six months before PA is requested for any anti-obesity drug. If the member meets a weight loss goal of at least 10 pounds during the first six months of treatment, PA may be requested for an additional six months of treatment. If the member continues to lose weight, 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. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services.

ForwardHealth allows only two weight loss attempts with Xenical® during a member's lifetime.

If a member has reached his or her goal weight and continues treatment with Xenical® to maintain weight loss, a PA request may be approved for a maximum of six months if the member does not gain weight during the PA renewal period and the maximum treatment period of 24 months of drug therapy is not exceeded.

Submitting Prior Authorization Requests

PA requests for anti-obesity drugs must be submitted by prescribers or their designees, not pharmacy providers.

Prescribers or their billing providers are required to be certified by Wisconsin Medicaid to submit PA requests to ForwardHealth. Prescribers who are certified by Wisconsin Medicaid should indicate their name and NPI as the billing provider on PA requests. Prescribers who are not certified by Wisconsin Medicaid should indicate the name and NPI of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

PA requests for anti-obesity drugs may be submitted through the following:

- DAPO Center.
- Fax.
- Mail.

Note: Pharmacy providers cannot request PA for anti-obesity drugs using the STAT-PA system. If a PA request for anti-obesity drugs is submitted using the STAT-PA system, providers will receive a message that states, "Procedure not valid for STAT-PA."

Current, approved PAs will be honored until their expiration date. For members to continue taking an anti-obesity drug beyond an approved PA's expiration date, a new PA must be submitted.

PA request submission procedures apply to members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare.

Prior Authorization Requests Submitted by Fax or Mail

Prescribers may also submit PA requests for anti-obesity drugs by fax to (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

If a prescriber or his or her designee chooses to submit a paper PA request for anti-obesity drugs by fax or mail, the following must be completed and submitted to ForwardHealth:

- PA/RF for prescribers for drugs.
- Prior Authorization Drug Attachment for Anti-Obesity Drugs.
- Supporting documentation, as appropriate.

The Prior Authorization Fax Cover Sheet is available for providers submitting the forms and documentation by fax.

Prior authorization requests for anti-obesity drugs submitted 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 for Lovaza

Lovaza® is a preferred drug that requires clinical PA. To request PA for Lovaza®, prescribers are required to complete and submit to ForwardHealth the Prior Authorization Drug Attachment for Lovaza.

Lovaza® is not covered for members enrolled in the BadgerCare Plus Benchmark Plan and the BadgerCare Plus Core Plan.

Clinical Criteria

Clinical criteria for approval of a PA request for Lovaza® are the following:

- The member is 18 years of age or older.
- The member does not have an allergy or sensitivity to fish.
- Medical conditions (e.g., diabetes mellitus, hypothyroidism) that may contribute to hypertriglyceremia have been identified and are being managed appropriately.
- Medications (e.g., beta blockers, thiazides, estrogens) that may contribute to hypertriglyceremia have been identified and modified if appropriate.
- The member is aware of and compliant with lifestyle modifications (e.g., diet, exercise, weight loss, alcohol consumption) that

may improve triglyceride levels.
- The member currently has a triglyceride level of 500 mg/dL or greater, or for members with triglyceride levels below 500 mg/dL, the member must have both of the following:
    - A triglyceride level of 500 mg/dL or greater within the last five years. (*Note:* The test date of the triglyceride level must be indicated on the PA request.)
    - A current triglyceride level between 200 and 499 mg/dL while taking a fibrate or niacin. If a member's triglyceride level is below 200 mg/dL, a PA request will be denied.

Submitting Prior Authorization Requests

PA requests for Lovaza® must be submitted by prescribers or their designees, not pharmacy providers.

Prescribers or their billing providers are required to be certified by Wisconsin Medicaid to submit PA requests to ForwardHealth. Prescribers who are certified by Wisconsin Medicaid should indicate their name and NPI as the billing provider on PA requests. Prescribers who are not certified by Wisconsin Medicaid should indicate the name and NPI of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

PA requests for Lovaza® may be submitted through the following:

- DAPO Center.
- Fax.
- Mail.

Note: Pharmacy providers cannot request PA for Lovaza® using the STAT-PA system. If a PA request for Lovaza® is submitted using the STAT-PA system, providers will receive a message that states, "Procedure not valid for STAT-PA."

Current, approved PAs will be honored until their expiration date. For members to continue taking Lovaza® beyond an approved PA's expiration date, a new PA must be submitted.

PA request submission procedures apply to members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare.

Prior Authorization Requests Submitted by Fax or Mail

Prescribers may also submit PA requests for Lovaza® by fax to (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

If a prescriber or his or her designee chooses to submit a paper PA request for Lovaza® by fax or mail, the following must be completed and submitted to ForwardHealth:

- PA/RF for prescribers for drugs.
- Prior Authorization Drug Attachment for Lovaza.
- Supporting documentation, as appropriate.

The Prior Authorization Fax Cover Sheet is available for providers submitting the forms and documentation by fax.

Prior authorization requests for Lovaza® submitted 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.

Approved Prior Authorization Requests

If an initial PA request for Lovaza® is approved, the request will be approved for four months. For subsequent PA requests, the member's triglyceride levels must decrease by 20 percent from the baseline triglyceride level for a renewal PA request to be approved. Renewal requests may be approved for up to one year.

Lipid panels, including triglyceride levels, are required for each yearly PA renewal request thereafter.

Screening Computed Tomographic Colonography

All PA requests for screening CT 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.

Situations Requiring New Requests

Change in Billing Providers

Providers are required to submit a new PA 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.

Changes to Member Enrollment Status

Changes to a member's enrollment status may affect PA 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.

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.

Examples

Examples of when a new PA 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.

Services Not Performed Before Expiration Date

Generally, a new PA 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

Drug Authorization and Policy Override Center

The DAPO Center is a specialized drug helpdesk for prescribers, their designees, and pharmacy providers to submit PA 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.

With the establishment of the DAPO Center, ForwardHealth's goal is to streamline for prescribers and pharmacy providers the process for requesting policy overrides and PA for specific drugs and diabetic supplies. In addition, DAPO Center staff survey current pharmacy claims to identify potential drug therapy concerns.

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 certified by Wisconsin Medicaid to submit PA requests to ForwardHealth. Prescribers who are certified by Wisconsin Medicaid should indicate their name and NPI as the billing provider on PA requests. Providers who are not certified by Wisconsin Medicaid should indicate the name and NPI of the Wisconsin Medicaid-certified 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, 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 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 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.

Fax

Faxing of all PA requests to ForwardHealth may eliminate one to three days of mail time. The following are recommendations to avoid delays when faxing PA requests:

- 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 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) 221-4746, extension 80118.

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 or the PA/HIAS1 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) 221-4746, extension 80118, 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, such as the carbon PA/RF, 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.

ForwardHealth Portal Prior Authorization

Providers can use the following PA features on the ForwardHealth Portal to do the following:

- Submit PA requests and amendments for all services that require PA.
- Receive decision notice letters and returned provider review letters.
- Correct returned PA requests and PA amendment requests.
- Search and view previously submitted 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 requirements, NPI and related data are required on PAs 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 PAs with a status of "Approved" or "Approved with Modifications."

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, and display the form for the provider to complete.

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, 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 that was completed on the Portal.

*Please 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 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 the providers.

Additional Supporting Information

Providers may choose to submit additional supporting information via mail or fax. If additional supporting information is needed, 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.

For certain PA process types, providers can choose to upload electronic supporting information through the Portal. Files can be uploaded if the user selects a process type of 117 (Physician services), 124 (Dental services), or 125 (Orthodontic services). Photographs, X-rays and dental models may be uploaded through the Portal if the images are in a JPEG format or created with OrthoCad software (available free on the Web). Dental model OrthoCad files must be uploaded with an extension of ".3dm." JPEG files must be uploaded with an extension of ".jpg" or ".jpeg."

Mail

Any type of PA 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
6406 Bridge Rd
Madison WI 53784-0088

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

STAT-PA

Providers can submit STAT-PA 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 requests.

NPI 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.

Reimbursement

8

Archive Date:03/01/2011

Reimbursement:Amounts

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) may not exceed the BadgerCare Plus-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 BadgerCare Plus-allowed amount for a service (i.e., balance billing).

Other health insurance payments may exceed the BadgerCare Plus-allowed amount if no additional payment is received from the member or BadgerCare Plus.

Additional Reimbursement for Reporting Body Mass Index

ForwardHealth is collecting body mass index (BMI) 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.

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."

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 visit.

Examples of ancillary providers include non-Medicaid certifiable health care professionals such as staff nurses, dietician counselors, nutritionists, health educators, genetic counselors, and some nurse practitioners. (Nurse practitioners, nurse midwives, and anesthetists who are Medicaid certified 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 using the lowest appropriate level office or outpatient visit procedure code or other appropriate CPT 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.

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.

Electronic Funds Transfer

EFT 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. Electronic Funds Transfer 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 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 providers during their provisional certification 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 new "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 ForwardHealth Portal Electronic Funds Transfer User Guide and the Electronic Funds Transfer Fact Page 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.

Fee Schedules

Maximum allowable fee information is available on the ForwardHealth Portal in the following forms:

- Interactive fee schedule.
- Downloadable fee schedule in TXT 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.

Health Professional Shortage Areas

Enhanced reimbursement is provided to Medicaid-certified 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-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 Services* New Patient Established Patient Emergency Department Newborn Care	99201, 99202, 99203, 99204, 99205 99211, 99212, 99213, 99214, 99215 99281, 99282, 99283, 99284, 99285 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	90701, 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.

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 procedure codes 99381-99385 and 99391-99395).

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.

Maximum Daily Reimbursement

A physician services provider's reimbursement for all services performed on the same DOS for the same member may not exceed the amount established by ForwardHealth. Effective July 1, 2008, the maximum daily reimbursement amount is $2,331.37. The limit pertains to most physician services and services provided by nurse midwives, nurse practitioners, oral surgeons, physician assistants, and podiatrists. The maximum daily reimbursement amount does not apply to the following:

- Physician-administered drugs.
- DME.

ForwardHealth remittance information will indicate when the maximum daily reimbursement amount has been met.

Surgery Services Exceeding Six Hours

A provider may request additional reimbursement for a surgery exceeding six hours. A provider in this situation should submit a claim in the usual manner. Additional reimbursement may be requested for the allowed claim by submitting an Adjustment/Reconsideration Request with clinical documentation.

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.

Pediatric Services

Wisconsin Medicaid provides an enhanced reimbursement rate for office and other outpatient services (CPT codes 99201-99215) and emergency department services (CPT codes 99281-99285) for members 18 years of age and under. The enhanced reimbursement rates are indicated on the 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.

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, for members enrolled in BadgerCare Plus HMOs, Medicaid SSI 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 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 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 procedure code indicated.

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.

Physicians

Wisconsin Medicaid reimburses physicians the lesser of the physician's billed amount for a service or Wisconsin Medicaid's maximum allowable fee.

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.

Residents

Wisconsin Medicaid reimburses residents for physician services when:

- The resident is fully licensed to practice medicine and has obtained an NPI.
- 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.

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. 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.

Surgical Procedures

Surgical procedures performed by the same physician, for the same member, on the same DOS must be submitted on the same claim form. Surgeries that are billed on separate claim forms are denied.

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 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 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

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) 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.

Conditions That Must Be Met

A member may request a noncovered service, a covered service for which PA 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.

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 *only* the copayment amount from the member.

Situations When Member Payment Is Allowed

Providers may not collect payment from a member, or authorized person acting on behalf of the member, *except* for the following:

- Required member copayments for certain services.
- Commercial insurance payments made to the member.
- Spenddown.
- Charges for a private room in a nursing home or hospital.
- Noncovered services if certain conditions are met.
- Covered services for which PA 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 certification.

Copayment

Amounts

Information is available for DOS before January 1, 2011.

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 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	$2.00

BadgerCare Plus Benchmark Plan

Copayment for medical services provided under the BadgerCare Plus Benchmark Plan is $15.00 per visit regardless of number of services provided during that visit. There are no annual limits to copayments under the Benchmark Plan.

Copayments apply to the following:

- ESRD services (CPT 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 and laboratory services.

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 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.

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:

- Members under 18 years of age with incomes at or below 100 percent of the FPL. (For HealthCheck services, members under 19 years old are exempt.)
- Members under 18 years of age who are members of a federally recognized tribe regardless of income.
- Members enrolled in Medicaid because they are in foster care regardless of age.
- Members enrolled in Medicaid through subsidized adoption regardless of age.
- Members enrolled in Medicaid through the Katie Beckett program regardless of age.
- Nursing home residents.
- Members enrolled in Medicaid SSI HMOs or Medicaid special managed care programs receiving managed care-covered services.
- Pregnant women.

The following services do not require copayment:

- Case management services.
- Crisis intervention services.
- CSP services.
- Emergency services.
- Family planning services, including sterilizations.
- Home care services.
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.

- PDN and PDN services for ventilator-dependent members.
- SBS.
- Substance abuse day treatment services.
- Surgical assistance.

BadgerCare Plus Standard Plan Exemptions

Providers are prohibited from collecting copayment from the following BadgerCare Plus Standard Plan members:

- Members in nursing homes.
- Members under 18 years old who are members of a federally recognized tribe regardless of income.
- Members under 18 years old with incomes at or below 100 percent of the FPL.
- Pregnant women.

The following services do not require copayment:

- Case management services.
- Crisis intervention services.
- CSP services.
- Emergency services.
- Family planning services, including sterilizations.
- Home care services.
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- PDN and PDN services for ventilator-dependent members.
- SBS.
- Substance abuse day treatment services.
- Surgical assistance.

Wisconsin Well Woman Medicaid Exemptions

Providers are prohibited from collecting copayment from members who have been enrolled into WWWMA from the BadgerCare Plus Benchmark Plan or the BadgerCare Plus Core Plan for any Medicaid covered service.

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.
- 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.

Copayment Limit for Physician Services

Information for DOS before July 1, 2009, is available.

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.

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.

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.

Chapter 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

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:

- B-3.
- Crime Victim Compensation Fund.
- GA.
- HCBS waiver programs.
- IDEA.
- Indian Health Service.
- Maternal and Child Health Services.
- WCDP.
    - 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.

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.
- Other governmental benefits.

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.

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

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.
- Mental health and substance abuse services. (Refer to the mental health and substance abuse, home or community service area of the Online Handbook for information regarding certification 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.

Reimbursement Not Available Through a Factor

BadgerCare Plus will not reimburse providers through a factor, either directly or by virtue of a power of attorney given to the factor by the provider. A factor is an organization (e.g., a collection agency) or person who advances money to a provider for the purchase or transferal of the provider's accounts receivable. The term "factor" does not include business representatives, such as billing services, clearinghouses, or accounting firms, which render statements and receive payments in the name of the provider.

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 delivery charges are included in the reimbursement for DME items.

Resources

9

Archive Date:03/01/2011

Resources:Contact Information

Member Services

Providers should refer ForwardHealth members with questions to Member Services. The telephone number for Member Services is for member use only.

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 certified 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 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 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 at (800) 362-3002.

If contacting a field representative by e-mail, providers should ensure that no individually identifiable health information, known as PHI,

is included in the message. PHI can include things such as the member's name combined with his/her identification number or SSN.

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 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.

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, and WWWP 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.
- Certification.
- COB (e.g., verifying a member's other health insurance coverage).
- Assistance with completing forms.
- Assistance with remittance information and claim denials.
- Policy clarification.
- PA 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 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.
- Amount billed.
- RA.
- Procedure code of the service in question.
- Reference to any provider publications that address the inquiry.

Call Center Correspondent Team

The ForwardHealth call center correspondents are organized to respond to telephone calls from providers. Correspondents offer assistance and answer inquiries specific to the program (i.e., Medicaid, WCDP, or WWWP) or to the service area (i.e., pharmacy services, hospital services) in which they are designated.

Call Center Menu Options and Inquiries

Providers contacting Provider Services are prompted to select from the following menu options:

- WCDP and WWWP (for inquiries from all providers regarding WCDP or WWWP).
- Dental (for all inquiries regarding dental services).
- Medicaid or SeniorCare Pharmacy (for pharmacy providers) or STAT-PA for STAT-PA inquiries, including inquiries from pharmacies, DME providers for orthopedic shoes, and HealthCheck providers for environmental lead inspections.
- Medicaid and BadgerCare Plus institutional services (for inquiries from providers who provide hospital, nursing home, home health, personal care, ESRD, and hospice services or NIP).
- Medicaid and BadgerCare Plus professional services (for inquiries from all other providers not mentioned in the previous menu prompts).

Walk-in Appointments

Walk-in appointments offer face-to-face assistance for providers at the Provider Services office. Providers are encouraged to contact the Provider Services Call Center to schedule a walk-in appointment.

Written Inquiries

Providers may contact Provider Services through the Portal by selecting the "Contact Us" link. Provider Services will respond to the inquiry by the preferred method of response indicated within five business days. All information is transmitted via a secure connection to protect personal health information.

Providers may submit written inquiries to ForwardHealth by mail using the Written Correspondence Inquiry 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
6406 Bridge Rd
Madison WI 53784-0005

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.

Provider Suggestions

The DHCAA 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 form.

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.

Electronic Data Interchange

Companion Documents

Purpose of Companion Documents

ForwardHealth companion documents provide trading partners with useful technical information on ForwardHealth's standards for nationally recognized electronic transactions.

The information in companion documents applies to BadgerCare Plus, Medicaid, SeniorCare, WCDP, and WWWP. Companion documents are intended for information technology and systems staff who code billing systems or software.

The companion documents complement the federal HIPAA 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, and enrollment inquiries).

Companion documents do *not* include program requirements, but help those who create the electronic formats for electronic data exchange.

Companion documents 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 Helpdesk).
- Transaction formats.

Revisions to Companion Documents

Companion documents may be updated as a result of changes to federal requirements. When this occurs, ForwardHealth will do the following:

- Post the revised companion document 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 the revised companion documents on the Portal. If trading partners do not follow the revisions identified in the companion document, transactions may not process successfully (e.g., claims may deny or process incorrectly).

A revision log located at the front of the revised companion document lists the changes that have been made. The date on the companion document reflects the last date the companion document was revised. In addition, the version number located in the footer of the first page is changed with each revision.

Data Exchange Methods

The following data exchange methods are supported by the EDI 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 5.1, 270/271, or 276/277 transactions via an approved clearinghouse.

The EDI Helpdesk supports the exchange of the transactions for BadgerCare Plus, Medicaid, SeniorCare, WCDP, and WWWP.

Electronic Data Interchange Helpdesk

The EDI 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.

Electronic Transactions

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 Department, trading partners may exchange the following electronic transactions:

- 270/271. The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.
- 276/277. The 276 is the electronic transaction for checking claim status. The 277 is received in response.
- 835. The electronic transaction for receiving remittance information.
- 837. The electronic transaction for submitting claims and adjustment requests.
- 997. 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 5.1 Telecommunication Standard for Retail Pharmacy Claims. The real-time POS electronic transaction for submitting pharmacy claims.

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. The PES software allows providers to submit 837 transactions and download the 997 and the 835 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 Helpdesk.

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

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 Helpdesk.

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

270/271 Transactions

The 270/271 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, 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 certification 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 certification on file with ForwardHealth. The 271 response will report the provider ID that was indicated on the 270.

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 enrollment.
- Medicare enrollment.
- Limited benefits categories.
- Any other commercial health insurance coverage.
- Exemption from copayments for BadgerCare Plus members.

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 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 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.

Copayment Information

If a member is enrolled in BadgerCare Plus and is exempted 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 and is required to pay copayments, providers 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.

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 to receive the most current enrollment information through the following methods:

- ForwardHealth Portal.
- WiCall, Wisconsin's AVR system.
- Commercial enrollment verification vendors.
- 270/271 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.

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.

Entering Dates of Service

Enrollment information is provided based on a "From" DOS and a "To" DOS that the provider enters when making the enrollment inquiry. For enrollment inquires, a "From" DOS is the earliest date for which the provider is requesting enrollment information and the "To" DOS is the latest date for which the provider is requesting enrollment information.

Providers should use the following guidelines for entering DOS when verifying enrollment for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, or WCDP 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.

Member Forgets ForwardHealth Identification Card

Even if a member does not present a ForwardHealth identification card, a provider can use Wisconsin's EVS 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 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.

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 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.

Responses Are Based on Financial Payer

When making an enrollment inquiry through Wisconsin's EVS, 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.
- WWWP.

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 Benefit and Family Planning Only Services at the same time, both of which are administered by Medicaid.)

Forms

An Overview

ForwardHealth requires providers to use a variety of forms for PA, claims processing, and documenting special circumstances.

Fillable Forms

Most forms may be obtained from the Forms page of the ForwardHealth Portal.

Forms on the Portal are available as fillable PDF 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.

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
  6406 Bridge Rd
  Madison WI 53784-0003

Portal

ASC X12 Version 5010 and NCPDP Version D.0 Implementation Page

ForwardHealth has established a page on the ForwardHealth Portal designed to keep providers and trading partners informed of important dates and information related to the implementation of the new HIPAA ASC X12 version 5010 and NCPDP telecommunication standard version D.0. Providers, trading partners, partners, MCOs, and other interested parties are encouraged to check the 5010 page of the Portal often, as ForwardHealth will post new information regularly.

As information becomes available, ForwardHealth plans to include the following on the version 5010 and version D.0 page of the Portal:

- Questions and answers about the transition to the new standards.
- Companion documents for the new standards.
- External compliance testing schedule and procedures.
- Links to national resources for version 5010 and version D.0 transactions.
- An e-mail address to which providers and trading partners can send their questions (*forwardhealth5010support@wi.gov*).

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 through the secure Portal.

Conducting Recertification Via the ForwardHealth Portal

Providers can conduct recertification online via a secure recertification area of the ForwardHealth Portal.

Cost Share Reports for Long-Term Managed Care Organizations

Individual cost share reports for long-term care MCOs that provide Family Care, Family Care Partnership, and PACE services are available via the secure area of the ForwardHealth Portal and can be downloaded as an Excel file.

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 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 ForeardHealth 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.

A user's guide containing detailed instructions for performing these functions can be found on the Portal.

Designating a Trading Partner to Receive 835 Health Care Claim Payment/Advice Transactions

Providers must designate a trading partner to receive their 835 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 Helpdesk or submit a paper form.

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.
- 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 (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.

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.
- 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.

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.

HealthCheck Information Available Through the ForwardHealth Portal

HealthCheck providers can access outreach reports and view screening history, the Periodicity Schedule, and the WIR 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 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.dhfswir.org/*. Login and password requirements for WIR apply regardless of the link used to reach the Web site.

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.

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 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.

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 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.

Managed Care Organization Portal

Information and Functions Through the Portal

The MCO 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:

- Certified Provider Listing of all Medicaid-certified 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 with date of birth and a "from DOS" 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, and taxonomy code (if applicable), and provider type and specialty.
- HealthCheck information.
- MCO contact information.
- Technical contact information. Entries may be added via the Portal.

Managed Care Organization Portal Reports

The following reports are generated to MCOs 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.

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.

Obtaining a Personal Identification Number

To establish an account on the ForwardHealth Portal, providers are required to obtain a PIN. 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 recertification on the Portal. Providers will receive a separate PIN for recertification.

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 certification. A separate PIN will be needed for each provider certification. Health care providers will need to supply their NPI 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 certifications. Select the correct certification for the account. The taxonomy code, ZIP+4 code, and financial payer for that certification will be automatically populated. Enter the SSN or TIN.
    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.
- WCDP.
- The WWWP.

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.

Online Handbook

The Online Handbook allows providers access to all policy and billing information for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and WCDP 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:

- Certification.
- Claims.
- Coordination of Benefits.
- Managed Care.
- Member Information.
- Prior Authorization.
- 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.)

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.
- Designate which trading partner is eligible to receive the provider's 835.
- 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.
- Track provider-submitted PA requests.

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.
- 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. 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 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.

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 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.

Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their Portal account. Clerks may be assigned one or many roles (i.e., claims, PA, 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 certifications). 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 enrollment verification for one Portal account, and HealthCheck inquires for another).

Submitting Prior Authorization and Amendment Requests Via the Portal

Nearly all service areas can submit PAs 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.

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 fee schedules for Medicaid, BadgerCare Plus, and WCDP are interactive and searchable. Providers can enter the DOS, 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 information are incorporated immediately after policy changes have been issued in *Updates*. The Online Handbook also links to the ForwardHealth Publications page, an archive section where providers can research past policy changes.

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 Certification

Providers can speed up the certification process for Medicaid by completing a provider certification application via the Portal. Providers can then track their application by entering their ATN 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.
- E-mail subscription service for *Updates*. Providers can sign up 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.

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 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 through the secure Portal.

Submitting Prior Authorization and Amendment Requests Via the Portal

Nearly all service areas can submit PAs via the 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 PA 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.

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.
- 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 system or the EVS (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.
- Designate which trading partner is eligible to receive the provider's 835.
- 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.
- Track provider-submitted PA requests.

System and Browser Requirements

The following table lists the recommended system and browser requirements for using the Portal. PES 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	

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 software and upgrade information.
- EDI companion documents.

In the secure Trading Partner area of the Portal, trading partners can exchange electronic transactions with ForwardHealth.

Updates

Full Text Publications Available

Providers may request full-text versions of *ForwardHealth Updates* to be mailed to them by calling Provider Services.

General Information

ForwardHealth Updates are the first source of provider information. *Updates* announce the latest information on policy and coverage changes, PA submission requirements, claims submission requirements, and training announcements.

The *ForwardHealth Update Summary* is distributed on a monthly basis and contains an overview of *Updates* published that month. Providers with a ForwardHealth Portal account will be notified through their Portal mailbox when the *Update Summary* is available on the Portal. Providers without a Portal account will receive a paper copy of the *Update Summary* unless they have opted out of receiving paper publications.

Providers may obtain copies of *Updates* listed in the *Update Summary* from the Portal. A Web address that directly links providers to a list of each month's *Updates* is listed in the *Update Summary*. Providers may then print specific articles to keep on paper 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 immediately after policy changes have been issued in *Updates*. The Online Handbook also includes a link to the ForwardHealth Publications page, an archive section where providers can research past changes.

Multiple Ways to Access ForwardHealth Publications

Providers may choose to receive notification on paper via U.S. mail or through a new 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 much sooner than on paper. Certain providers may choose not to receive *Updates* and the monthly *Update Summary*.

ForwardHealth Portal Account

Providers who establish a Portal account will not receive the *Update Summary* on paper through the U.S. mail. Providers are still bound to the program's rules, policies, and regulations even if they do not receive the *Update Summary* through the mail.

Mail

ForwardHealth will mail the monthly *Update Summary* to providers who do not have a Portal account.

E-mail Subscription Service

Providers and other interested parties may sign up on the Portal to receive e-mail notifications of new provider publications. Users are able to select, by program (Wisconsin Medicaid, BadgerCare Plus, or WCDP) and provider type (e.g., physician, hospital, DME 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. Providers who sign up for an e-mail subscription will continue to receive paper copies of the monthly *Update Summary* unless they have a Portal account or have opted out of receiving paper publications.

Users may sign up for an e-mail subscription by following these steps:

1. Go to the Portal.
2. Click on the "Providers" link or button.
3. Click the "Subscribe to Provider Notifications" link from the Quick Links box on the right side of the screen.
4. Register by supplying e-mail address.

Users may register for additional electronic subscriptions by adding service areas listed under "Available Subscriptions" on the right side of the subscriptions page.

WiCall

Enrollment Inquiries

WiCall is an AVR system that allows providers with touch-tone telephones direct access to enrollment information. A WiCall Quick Reference Guide for Enrollment Inquiries is available.

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 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 on the DOS or within the DOS range selected, HPSA information will be given.
- MCO: 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.

Entering Letters into WiCall

For some WiCall inquries, health care providers are required to enter their taxonomy code with their NPI. 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.

Information Available Via WiCall

WiCall, ForwardHealth's AVR 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 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 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, or WWWP by entering their provider ID, member identification number, DOS, 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. 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/procedure code, revenue code, or ICD-9-CM 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.

Quick Reference Guide

The WiCall AVR Quick Reference Guide displays the information available for WiCall inquiries.