Claims

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Claims:Adjustment Requests

Topic #814

Allowed Claim

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

Topic #815

Denied Claim

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

Topic #512

Electronic

837 Transaction

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

Provider Electronic Solutions Software

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

Portal Claim Adjustments

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

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

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

Topic #513

Follow-Up

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

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

Topic #515

Paper

Paper adjustment requests must be submitted using the Adjustment/Reconsideration Request (F-13046 (02/2025)) form.

Topic #816

Processing

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

Topic #514

Purpose

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

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

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

Topic #645

Examples of When to Submit Adjustment Requests

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

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

Topic #4857

Submitting Paper Attachments with Electronic Claim Adjustments

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

Good Faith Claims

Topic #518

Definition of Good Faith Claims

A good faith claim may be submitted when a claim is denied due to a discrepancy between the member's enrollment information in the claims processing system and the member's actual enrollment. If a member presents a temporary identification card for BadgerCare Plus or Family Planning Only Services, the provider should check the member's enrollment via Wisconsin's EVS (Enrollment Verification System) and, if the enrollment is not on file yet, make a photocopy of the member's temporary identification card.

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

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

Overpayments

Topic #528

Adjustment Request vs. Cash Refund

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

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

Topic #532

Adjustment Requests

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

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

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

Electronic Adjustment Requests

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

Paper Adjustment Requests

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

- Submit an Adjustment/Reconsideration Request (F-13046 (02/2025)) form through normal processing channels (not timely filing), regardless of the DOS
- Indicate the reason for the overpayment, such as a duplicate reimbursement or an error in the quantity indicated on the claim

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

Topic #533

Cash Refunds

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

ForwardHealth
Financial Services Cash Unit
313 Blettner Blvd
Madison WI 53784

Topic #531

ForwardHealth-Initiated Adjustments

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

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

Topic #530

Requirements

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

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

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

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

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

Topic #8417

Voiding Claims

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

Responses

Topic #540

An Overview of the Remittance Advice

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

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

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

Topic #5091

National Provider Identifier on the Remittance Advice

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

Topic #4818

Calculating Totals on the Remittance Advice for Adjusted and Paid Claims

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

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

Topic #534

Claim Number

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

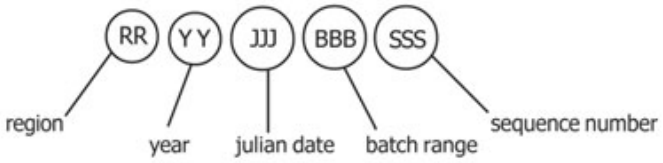
control number)). However, denied real-time compound and noncompound claims are not assigned an ICN, but receive an authorization number. Authorization numbers are not reported to the RA (Remittance Advice) or 835 (835 Health Care Claim Payment/Advice).

Interpreting Claim Numbers

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

Interpreting Claim Numbers

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



Type of Number and Description	Applicable Numbers and Description
Region — Two digits indicate the region. The region indicates how ForwardHealth received the claim or adjustment request.	10 — Paper Claims with No Attachments 11 — Paper Claims with Attachments 20 — Electronic Claims with No Attachments 21 — Electronic Claims with Attachments 22 — Internet Claims with No Attachments 23 — Internet Claims with Attachments 25 — Point-of-Service Claims 26 — Point-of-Service Claims with Attachments 40 — Claims Converted from Former Processing System 45 — Adjustments Converted from Former Processing System 50–59 — Adjustments 67 — Cash Payment Applied 80 — Claim Resubmissions 90–91 — Claims Requiring Special Handling
Year — Two digits indicate the year ForwardHealth received the claim or adjustment request.	For example, the year 2008 would appear as 08.
Julian date — Three digits indicate the day of the year, by Julian date, that ForwardHealth received the claim or adjustment request.	For example, February 3 would appear as 034.
Batch range — Three digits indicate the batch range assigned to the claim.	The batch range is used internally by ForwardHealth.
Sequence number — Three digits indicate the sequence number assigned within the batch range.	The sequence number is used internally by ForwardHealth.

Topic #535

Claim Status

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

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

ForwardHealth claims generally fall into one of three statuses:

- Pay—The claim has been approved for payment.
- Deny—The claim was not approved for payment.
- Suspend—The claim is awaiting further review by ForwardHealth before a decision is made on how the claim will be adjudicated.

Refer to the ForwardHealth Portal Claim Status Information Instruction Sheet on the User Guides page of the Portal for additional information regarding claim status.

Topic #22277

Claims Denial Adjustment/Review Request

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

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

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

- If the claim is denied, the provider may resubmit the claim with supporting documentation to Provider Services Written Correspondence using the Written Correspondence (F-01170 (07/2012)) form with the "other (briefly explain the situation in question below)" box checked and the words "medical consultant review requested" written on the form.
- If the original claim is in an allowed status, the provider may submit an Adjustment/Reconsideration Request (F-13046 (02/2025)) form with supporting documentation and the "medical consultant review requested" box checked on the form to Provider Services Written Correspondence.

Topic #644

ClaimsXten Review

ForwardHealth monitors all professional claims for compliance with reimbursement policy using an automated procedure coding review software known as Change Healthcare ClaimsXten. ClaimsXten reviews claims submitted for billing inconsistencies and errors during claims processing. Medicaid programs in other states, insurance companies, and Medicare all use similar software.

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

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

ClaimsXten will be reviewed on a regular basis and changes will be made as needed based on industry best practices. In addition to adding new procedure codes, ClaimsXten may add or revise claim editing information based on an ongoing review of the software knowledge base. This ongoing process helps to ensure that the default clinical content used in ClaimsXten is clinically appropriate and within national standards.

Areas Monitored by ClaimsXten

ClaimsXten uses rules to monitor certain claim situations.

ClaimsXten rules adopted by ForwardHealth are subject to change or revision. This is not a comprehensive list of all claim edits, but rather examples of areas where edit rules will be implemented via ClaimsXten. Reference to more specific ForwardHealth coverage and reimbursement policy, where applicable, is indicated.

ForwardHealth uses ClaimsXten software to monitor the following situations:

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

ClaimsXten 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 ClaimsXten will review the claim.

Unbundled and Rebundled 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. ClaimsXten considers the single, most appropriate procedure code for reimbursement when unbundling is detected.

If certain procedure codes are submitted, ClaimsXten rebundles them into the single most appropriate procedure code. For example, if a provider submits a claim with two or more procedure codes for the same type of wound with varying sizes, ClaimsXten rebundles them to a procedure code that would encompass the total size.

ClaimsXten will also total billed amounts for individual procedures. For example, if the provider bills three procedures at $20, $30, and $25, ClaimsXten rebundles them into a single procedure code, adds the three amounts, and calculates the billed amount for a new 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 scope procedure is considered integral to the performance of the prostate procedure and would be denied as a separately billed item.

When a procedure is either incidental or integral to a major procedure, ClaimsXten 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.

An example of a mutually exclusive situation is when the repair of the organ can be performed by two different methods. One repair method must be chosen to repair the organ and must be reported. A second example is the reporting of an "initial" service and a "subsequent" service. It is contradictory for a service to be classified as both an initial and a subsequent service at the same time.

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

Medical Visit Billing Errors

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

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

For example, if a provider submits a procedure code for a major surgical procedure as well as for the initial hospital care per day, ClaimsXten denies the initial hospital care procedure as a visit when submitted with the major procedure with the same date of service. The major procedure has a 90-day global surgical period and the postoperative visit is not separately reimbursable.

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. ClaimsXten bases the preoperative and postoperative periods on designations in the CMS National Physician Fee Schedule.

For example, if a provider submits a procedure code for an office visit for E&M with a DOS of 11/02/21 and a related surgical procedure with a DOS of 11/03/21, ClaimsXten may deny the procedure code for the office visit as a preoperative visit.

Assistant Surgeon Billing Errors

ClaimsXten develops and maintains assistant surgeon values using the CMS Physician Fee Schedule as its primary source. Providers should refer to the Medicare Physician Fee Schedule for procedure codes where a surgery assistant may be paid. These codes are denoted with an indicator of "2" in the Assistant at Surgery column of the Medicare Physician Fee Schedule.

ForwardHealth's Assistant Surgeon Fee Schedule reflects procedure codes allowable with an assistant surgeon designation consistent with ClaimsXten.

For example, if a provider bills a procedure code for a surgery with a modifier representing an assistant surgeon, and ClaimsXten

determines that the procedure does not require an assistant surgeon, the procedure-modifier combination will be denied.

Topic #4746

Cutback Fields on the Remittance Advice for Adjusted and Paid Claims

Cutback fields indicate amounts that reduce the allowed amount of the claim. Examples of cutbacks include other insurance, member copays, 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 copays or spenddowns) will be indicated on the RA (Remittance Advice); the detail line EOB (Explanation of Benefits) codes inform providers that an amount was deducted from the total reimbursement but may not indicate the exact amount.

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

Topic #8617

Duplicate Claim Denials Within Seven Days

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

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

ForwardHealth
Provider Services Written Correspondence
313 Blettner Blvd
Madison WI 53784

Topic #537

Electronic Remittance Information

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

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

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

Text File

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

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

Comma-Separated Values Downloadable File

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

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

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

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

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

835

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

Provider Electronic Solutions Software

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

Topic #4822

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

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

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

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

TEXT File

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

CSV File

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

Topic #13437

ForwardHealth-Initiated Claim Adjustments

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

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

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

Topic #4820

Identifying the Claims Reported on the Remittance

Advice

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

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

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

Topic #11537

National Correct Coding Initiative

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

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

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

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

Medically Unlikely Detail Edits

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

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

Procedure-to-Procedure Detail Edits

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

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

Quarterly Code List Updates

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

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

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

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

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

- Complete the Adjustment/Reconsideration Request (F-13046 (02/2025)) form. In Element 16, select the "Consultant review requested" checkbox and the "Other/comments" checkbox. In the "Other/comments" text box, indicate "Reconsideration of an NCCI denial."
- Attach notes/supporting documentation.
- Submit a claim, Adjustment/Reconsideration Request, and additional notes/supporting documentation to ForwardHealth for processing.

Topic #539

Obtaining the Remittance Advice

Providers are required to access their secure ForwardHealth provider Portal account to obtain RAs (Remittance Advices). The secure Portal allows providers to conduct business and exchange electronic transactions with ForwardHealth. A separate Portal account is required for each financial payer.

Providers who do not have a ForwardHealth provider Portal account may request one.

RAs are accessible to providers in a TXT (text) format via the secure provider Portal account. The TXT format file is generated per financial payer and listed by RA number and RA date on the secure provider Portal account under "View Remittance Advices" menu at the top of the provider's Portal home page. RAs from the last 121 days are available in the TXT format.

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

Topic #4745

Overview of Claims Processing Information on the Remittance Advice

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

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

The claims processing sections reflect the types of claims submitted, such as the following:

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

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

- Adjusted claims
- Denied claims
- Paid claims

Claim Types	Provider Types
Dental claims	Dentists, dental therapists, dental hygienists, HealthCheck agencies that provide dental services
Inpatient claims	Inpatient hospital providers and institutes for mental disease providers
Long term care claims	Nursing homes
Medicare crossover institutional claims	Most providers who submit claims on the UB-04
Medicare crossover professional claims	Most providers who submit claims on the 1500 Health Insurance Claim Form ((02/12))
Noncompound and compound drug claims	Pharmacies and dispensing physicians
Outpatient claims	Outpatient hospital providers and hospice providers
Professional claims	Ambulance providers, ambulatory surgery centers, anesthesiologist assistants, audiologists, case management providers, certified registered nurse anesthetists, chiropractors, community care organizations, community support programs, crisis intervention providers, day treatment providers, family planning clinics, federally qualified health centers, HealthCheck providers, HealthCheck Other Services providers, hearing instrument specialists, home health agencies, independent labs, individual

	medical supply providers, medical equipment vendors, mental health/substance abuse clinics, nurses in independent practice, nurse practitioners, occupational therapists, opticians, optometrists, personal care agencies, pharmacists, physical therapists, physician assistants, physician clinics, physicians, podiatrists, portable X-ray providers, prenatal care coordination providers, psychologists, rehabilitation agencies, respiratory therapists, rural health clinics, school-based services providers, specialized medical vehicle providers, speech and hearing clinics, speech-language pathologists, therapy groups

Topic #4821

Prior Authorization Number on the Remittance Advice

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

Topic #4418

Reading Non-Claims Processing Sections of the Remittance Advice

Address Page

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

Banner Messages

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

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

Explanation of Benefits Code Descriptions

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

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

Financial Transactions Page

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

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

Refunds are payments made to providers for overpayments.

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

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

For decreasing claim adjustments listed on the RA, a separate accounts receivable will be established and will be listed in the Financial Transactions section. The accounts receivable will be established for the entire amount of the original paid claim. Providers will see net difference between the claim and the adjustment reflected on the RA.

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

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

Service Code Descriptions

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

Summary

The Summary section reviews the provider's claim activity and financial transactions with the payer (Medicaid, HDAP (Wisconsin HIV Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)) for the current financial cycle, the month-to-date, and the year-to-date, if applicable.

Under the "Claims Data" heading, providers can review the total number of claims that have been paid, adjusted, or denied along with the total amount reimbursed for all paid and adjusted claims. Only WWWP providers will see amounts reported for "Claims in Process." Other providers will always see zeroes in these fields.

Under the "Earnings Data" heading, providers will see total reimbursement amounts for other financial transactions, such as reimbursement for OBRA (Omnibus Budget Reconciliation Act of 1987) Level 1 screening, reimbursement for OBRA Nurse Aid Training/Testing, and capitation payments.

Note: HMOs should note that capitation payments are only reported in the Summary section of the RA. HMOs receive supplemental reports of their financial transactions from ForwardHealth.

The "Earnings Data" portion also summarizes refunds and voids and reports the net payment for the current financial cycle, the month-to-date, and the year-to-date, if applicable.

Providers should note that the Summary section will include outstanding checks 90 days after issuance and/or payments made to lien holders, if applicable.

Topic #368

Reading the Claim Adjustments Section of the Remittance Advice

Providers receive a Claim Adjustments section in the RA (Remittance Advice) if any of their claims were adjusted during the current financial cycle. A claim may be adjusted because one of the following occurred:

- An adjustment request was submitted by the provider.
- ForwardHealth initiated an adjustment.
- A cash refund was submitted to ForwardHealth.

To adjust a claim, ForwardHealth recoups the **difference**—or pays the **difference**—between the original claim amount and the claim adjustment amount. This difference will be reflected on the RA.

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

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

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

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

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

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

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

Topic #4824

Reading the Claims Denied Section of the Remittance Advice

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

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

Sample Professional Services Claims Denied Section of the Remittance Advice

Remittance Advice — Professional Service Claims Denied Sample

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

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

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

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

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

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


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

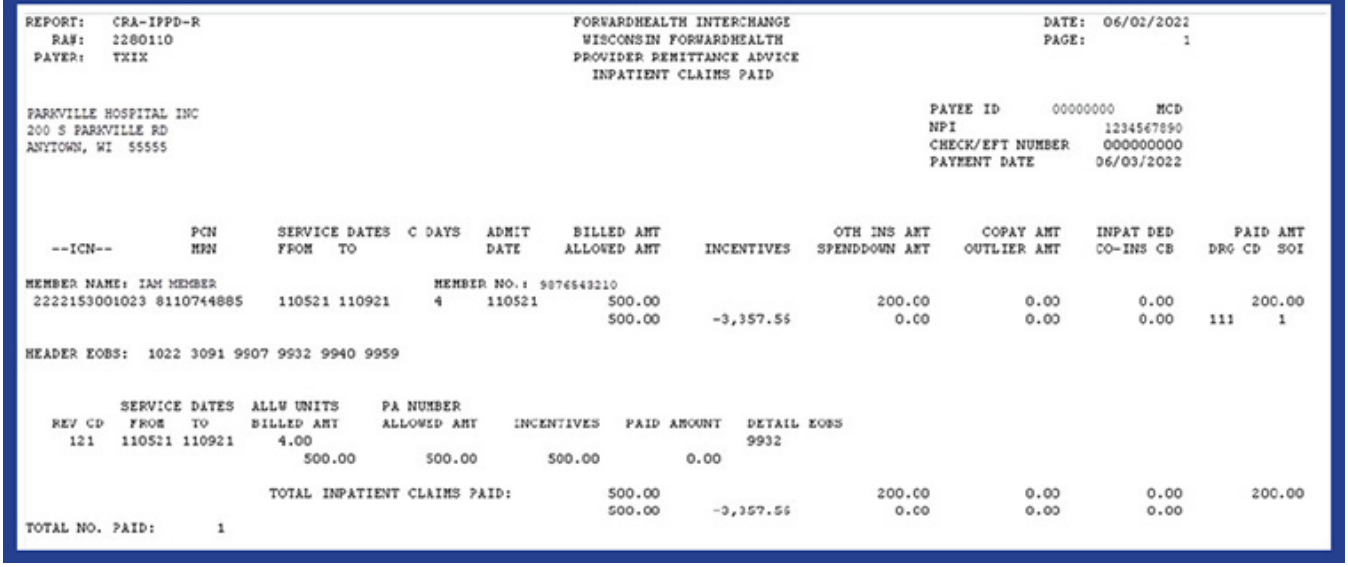
Topic #4825

Reading the Claims Paid Section of the Remittance Advice

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

In a paid claims section, providers will see the original claim information reported along with EOB (Explanation of Benefits) codes for both the header and the detail lines, if applicable. Providers should refer to the EOB Code Description section of the RA for more information about how the reimbursement amount was determined. The Incentives column is calculated in accordance with the 835 (835 Health Care Claim Payment/Advice) standards to balance among the service line, the claim, and the transaction.

Sample Inpatient Claims Paid Section of the Remittance Advice



```
REPORT:   CRA-IPPD-R                                  FORWARDHEALTH INTERCHANGE                          DATE:  06/02/2022
   RA#:   2280110                                      WISCONSIN FORWARDHEALTH                           PAGE:           1
 PAYER:   TXIX                                        PROVIDER REMITTANCE ADVICE
                                                        INPATIENT CLAIMS PAID

PARKVILLE HOSPITAL INC                                                                    PAYEE ID      00000000     MCD
200 S PARKVILLE RD                                                                        NPI                1234567890
ANYTOWN, WI  55555                                                                        CHECK/EFT NUMBER    000000000
                                                                                          PAYMENT DATE       06/03/2022


                  PCN       SERVICE DATES  C DAYS   ADMIT     BILLED AMT                  OTH INS AMT     COPAY AMT    INPAT DED       PAID AMT
   --ICN--        MRN       FROM   TO              DATE     ALLOWED AMT     INCENTIVES   SPENDDOWN AMT   OUTLIER AMT   CO-INS CB    DRG CD  SOI

MEMBER NAME: IAM MEMBER                        MEMBER NO.: 9876543210
 2222153001023 8110744885    110521 110921     4     110521        500.00                        200.00          0.00         0.00        200.00
                                                                    500.00      -3,357.56           0.00          0.00         0.00    111     1

HEADER EOBS:  1022 3091 9907 9932 9940 9959


          SERVICE DATES  ALLW UNITS     PA NUMBER
   REV CD   FROM   TO     BILLED AMT     ALLOWED AMT    INCENTIVES   PAID AMOUNT   DETAIL EOBS
     121   110521 110921     4.00                                                  9932
                              500.00        500.00        500.00          0.00

                         TOTAL INPATIENT CLAIMS PAID:          500.00                        200.00          0.00         0.00        200.00
                                                                    500.00      -3,357.56           0.00          0.00         0.00
TOTAL NO. PAID:       1
```

Topic #4828

Remittance Advice Financial Cycles

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

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

Topic #4827

Remittance Advice Generated by Payer and by Provider Enrollment

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

- Wisconsin Medicaid (Wisconsin Medicaid is the financial payer for the Medicaid, BadgerCare Plus, and SeniorCare programs)
- HDAP (Wisconsin HIV Drug Assistance Program)
- WCDP (Wisconsin Chronic Disease Program)
- WWWP (Wisconsin Well Woman Program)

A separate Portal account is required for each financial payer.

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

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

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

Topic #6237

Reporting a Lost Check

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

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

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

ForwardHealth
Financial Services
313 Blettner Blvd
Madison WI 53784

Topic #5018

Searching for and Viewing All Claims on the Portal

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

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

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

Topic #4829

Sections of the Remittance Advice

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

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

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

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

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

Remittance Advice Header Information

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

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

- The technical name of the RA section (for example, CRA-TRAN-R), which is an internal ForwardHealth designation
- The RA number, which is a unique number assigned to each RA that is generated
- The name of the payer (Medicaid, HDAP (Wisconsin HIV Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program))
- The Pay To address of the provider. The Pay To address is used for mailing purposes.

The following information is in the middle of the header:

- A description of the financial cycle
- The name of the RA section (for example, Financial Transactions or Professional Services Claims Paid)

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

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

Topic #544

Verifying Accuracy of Claims Processing

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

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

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

Responsibilities

Topic #516

Accuracy of Claims

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

ForwardHealth requires that all codes indicated on claims and PA (prior authorization) requests be valid, including:

- Diagnosis codes
- Revenue codes
- HCPCS (Healthcare Common Procedure Coding System) codes
- HIPPS (Health Insurance Prospective Payment System) codes
- CPT (Current Procedural Terminology) codes

Providers should refer to current national coding and billing manuals for information on valid code sets. ForwardHealth will:

- Deny claims received without valid diagnosis codes, revenue codes, and HCPCS, HIPPS, or CPT codes.
- For pharmacy providers, return PA requests received without valid codes to the provider.

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

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

Topic #366

Copay Amounts

Copay 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, copay amounts should not be included when indicating the amount paid by other health insurance sources.

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

Topic #22798

Payment Integrity Review Program

The PIR (Payment Integrity Review) program:

- Allows the OIG (Office of the Inspector General) to review claims prior to payment.
- Requires providers to submit all required documentation to support approval and payment of PIR-selected claims.

The goal of the PIR program is to further safeguard the integrity of Wisconsin DHS (Department of Health Services)-administered public assistance programs, such as BadgerCare Plus and Wisconsin Medicaid, from fraud, waste, and abuse by:

- Proactively reviewing claims prior to payment to ensure federal and state requirements are met.
- Providing enhanced, compliance-based technical assistance to meet the specific needs of providers.
- Increasing the monitoring of benefit and service areas that are at high risk for fraud, waste, and abuse.

Fraud, waste, and abuse includes the potential overutilization of services or other practices that directly or indirectly result in unnecessary program costs, such as:

- Billing for items or services that were not rendered.
- Incorrect or excessive billing of CPT (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) procedure codes.
- Unit errors, duplicate charges, and redundant charges.
- Billing for services outside of the provider specialty.
- Insufficient documentation in the medical record to support the charges billed.
- Lack of medical necessity or noncovered services.

Note: Review of claims in the PIR process does not preclude claims from future post-payment audits or review.

Payment Integrity Review Program Overview

When a provider submits a claim electronically via the ForwardHealth Portal, the system will display a message if the claim is subject to PIR. The message will instruct providers to submit supporting documentation with the claim. Providers have seven days to attach documentation to claims. The claim will automatically be denied if documentation is not attached within seven days.

Claims that meet PIR requirements may be eligible for payment once they are accurate and complete. Claims that do not meet PIR requirements may be denied or repriced. In these cases, providers are encouraged to:

- Review the EOB (Explanation of Benefits) for billing errors.
- Refer to the Online Handbook for claims documentation and program policy requirements.
- Correct the PIR billing errors and resubmit the claim.

Types of Payment Integrity Review

There are three types of review in the PIR program:

- Claims Review
- Pre-Payment Review
- Intermediate Sanctions

For each type of review, providers must submit supporting documentation that substantiates the CPT and/or HCPCS procedure codes on the claim.

	Claims Review	Pre-Payment Review	Intermediate Sanction
How claims are selected for review	A sampling of claims is selected from providers, provider types, benefit areas,	The OIG has reasonable suspicion that a provider is violating program rules.	The OIG has established cause that a provider is violating program rules.

	or service codes identified by the OIG.		
How providers are notified that selected claims are under review	The provider receives a message on the Portal.	The provider receives a Provider Notification letter and message on the Portal.	The provider receives a Notice of Intermediate Sanction letter and message on the Portal.
How to successfully exit the review	Claims are selected for review based on a pre-determined percentage of claim submissions of specific criteria. All providers who bill the service codes that are part of this criteria are subject to review, regardless of their compliance rates.	75% of a provider's reviewed claims over a three-month period must be paid as submitted. The number of claims submitted during the three-month period may not drop more than 10% of the provider's volume of submitted claims prior to pre-payment review.	The provider must meet parameters set during the sanction process.

Claims Review

In accordance with Wis. Admin. Code § DHS 107.02(2), the OIG may identify providers, provider types, benefit areas, or procedure codes, and based on those criteria, choose a sampling of claims to review prior to payment. When a claim submitted through the Portal that meets one of these criteria is selected for review, a message will appear on the Portal to notify the provider that the claim must be submitted with all necessary supporting documentation within seven calendar days. The claim will automatically be denied if documentation is not attached within seven days.

Pre-Payment Review

In accordance with Wis. Admin Code § DHS 106.11, if the OIG has cause to suspect that a provider is prescribing or providing services that are not necessary for members, are in excess of the medical needs of members, or do not conform to applicable professional practice standards, the provider's claims may be subject to review prior to payment. Providers who are subject to this type of review will receive a Pre-Payment Review Initial Notice letter, explaining that the OIG has identified billing practice or program integrity concerns in the provider's claims that warrant the review. This notice details the steps the provider must follow to substantiate their claims and the length of time their claims will be subject to review. Additionally, a message will appear on the Portal when the provider submits claims to notify the provider that certain claims must be submitted with all necessary supporting documentation within seven calendar days. The claim will automatically be denied if documentation is not attached within seven days.

For a provider to be considered for removal from pre-payment review, both of the following conditions must be met:

- 75% of the provider's reviewed claims over a three-month period are approved to be paid.
- The number of claims the provider submits during that three-month period may not drop more than 10% from their submitted claim amount prior to pre-payment review.

The OIG reserves the right to adjust these thresholds according to the facts of the case.

Intermediate Sanction Review

In accordance with Wis. Admin. Code § DHS 106.08(3)(d), if the OIG has established cause that a provider is violating program

rules, the OIG may impose an intermediate sanction that requires the provider's claims to be reviewed prior to payment. Providers who are subject to this type of review will be sent an official Intermediate Sanction Notice letter from the OIG that details the program integrity concerns that warrant the sanction, the length of time the sanction will apply, and the provider's right to appeal the sanction. The provider also will receive a message on the Portal when submitting claims that indicates certain claims must be submitted with the necessary supporting documentation within seven calendar days. The claim will automatically be denied if documentation is not attached within seven days.

For a provider to be considered for removal from an intermediate sanction, the provider must meet the parameters set during the sanction process.

Topic #547

Submission Deadline

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

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

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

Claims

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

Crossover Claims

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

Exceptions to the Submission Deadline

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

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

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

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

Topic #517

Usual and Customary Charges

For most services, providers are required to indicate their usual and customary charge when submitting claims. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to the program's benefits. For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost for providing the service.

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

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

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

Submission

Topic #17797

1500 Health Insurance Claim Form Completion Instructions

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

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

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

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

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

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

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Topic #10677

Advanced Imaging Services

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

Submitting Claims for Situations Exempt From the Prior Authorization Requirement

PA is not required for these advanced imaging services:

- Services provided during a member's inpatient hospital stay.
- Services provided when a member is in observation status at a hospital.
- Services provided as part of an emergency room visit.
- Services provided as an emergency service.
- Advanced breast imaging services that meet certain clinical criteria.

Service Provided During an Inpatient Stay

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

Institutional claims for advanced imaging services provided during a member's inpatient hospital stay are automatically exempt from PA requirements.

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

Service Provided for Observation Status

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

Providers using a paper institutional claim form should include modifier UA (Advanced imaging service is exempt from PA requirements) in Form Locator 44 (HCPCS (Healthcare Common Procedure Coding System)/Rate/HIPPS Code) with the

procedure code for the advanced imaging service. To indicate a modifier on an institutional claim, enter the appropriate five-digit procedure code in Form Locator 44, followed by the two-digit modifier. Providers submitting claims electronically using the 837I (837 Health Care Claim: Institutional) should refer to the appropriate companion guide for instructions on including a modifier.

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

Service Provided as Part of Emergency Room Visit

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

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

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

Service Provided as Emergency Service

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

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

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

Advanced Breast Imaging Services Under Certain Circumstances

For the first advanced breast imaging service within a 12-month period, providers must submit claims to ForwardHealth using these CPT (Current Procedural Terminology) procedure codes with modifier UA.

Procedure Code	Description
77046	Magnetic resonance imaging, breast, without contrast material; unilateral
77047	Magnetic resonance imaging, breast, without contrast material; bilateral
77048	Magnetic resonance imaging, breast, without and with contrast material(s); including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis) when performed; unilateral
77049	Magnetic resonance imaging, breast, without and with contrast material(s); including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis) when performed; bilateral
77061	Diagnostic digital breast tomosynthesis; unilateral
77062	Diagnostic digital breast tomosynthesis; bilateral

Topic #542

Attached Documentation

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

Topic #813

Examples of Required Additional Claim Documentation for Physician Services Providers

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

- An Abortion Certification Statements (F-01161 (09/2019)) form is attached to an abortion surgery claim.
- Physician-administered drugs that are not on the physician services maximum allowable fee schedule or unclassified drugs that do not require PA (prior authorization).
- Surgeries performed by cosurgeons.

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

Topic #19677

Bone-Anchored Hearing Devices and Cochlear Implants

Wisconsin Medicaid separately reimburses DME (durable medical equipment) providers for bone-anchored hearing devices and cochlear implants when the implant surgery is performed in an ASC (ambulatory surgery center) or outpatient hospital and the rendering surgeon has submitted a claim for the surgery. The POS (place of service) codes for these facilities are as follows:

- "11" (Office)
- "19" (Off Campus — Outpatient Hospital)
- "22" (On Campus — Outpatient Hospital)
- "24" (Ambulatory Surgical Center)

Claims for bone-anchored hearing devices and bone-anchored hearing device surgery and cochlear implants and cochlear implant surgery are required to be submitted in a professional claim format (for example, electronically using and 837 transaction, Direct Data Entry on the Portal, or Provider Electronic Solutions claims submission software, or on paper using the 1500 Health Insurance Claim Form).

The rendering surgeon is required to submit the claim for the surgery; the DME provider is required to submit the claim for the device.

Note: ForwardHealth will confirm that a claim for the bone-anchored hearing device surgery or cochlear implant surgery has been submitted prior to processing the DME provider's claim for the device. The DME provider is required to coordinate with the surgeon to ensure that the surgical claim is submitted first.

Topic #2605

Claim Submission for Clozapine Management Services

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

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

Providers submit claims for clozapine management services using the 837P (837 Health Care Claim: Professional) transaction or paper 1500 Health Insurance Claim Form ((02/12)). For each billing period, only one provider per member may be reimbursed for clozapine management with procedure code H0034 (Medication training and support, per 15 minutes) and modifier UD (clozapine management).

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

Place of Service Codes

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

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
19	Off Campus—Outpatient Hospital
22	On Campus—Outpatient Hospital
27	Outreach Site/Street
34	Hospice
71	State or Local Public Health Clinic
99	Other Place of Service

Topic #15117

Claim Submission for OnabotulinumtoxinA (Botox)

Professional Claims for Botox

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

Example of How to Determine Number of Units for Billing

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

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

Example

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

Since Botox comes in 100-unit and 200-unit single-use vials, the rendering provider could have used either one 200-unit vial or two 100-unit vials. (ForwardHealth allows billing for waste in either case.) For this example, the rendering provider used one 200-unit vial.

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

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

Topic #17477

Claim Submission for Services Rendered in Walk-In Retail or Convenient Care Clinics

When submitting claims to ForwardHealth for walk-in retail or convenient care clinic services, providers are required to indicate POS (place of service) code 17 to indicate services were provided in a walk-in retail or convenient care clinic.

Note: ForwardHealth does not accept disease-based bundled billing for E&M (evaluation and management) service codes when provided in POS 17.

The E&M service code billed is required to accurately represent the services rendered and to meet the criteria for the code as explained in the CPT (Current Procedural Terminology) manual.

Providers are required to maintain associated supporting documentation for the services rendered in the member's medical record as outlined in Wis. Admin. Code § DHS 106.02(9). Documentation should clearly support the services rendered and the procedure codes being submitted on claims.

Topic #23078

Claims Submission for Beyfortus

Beyfortus (nirsevimab), a monoclonal antibody, is used for the prevention of lower respiratory tract disease caused by RSV (respiratory syncytial virus) in infants or children.

Claims for Beyfortus must be submitted on professional claims.

On claims for Beyfortus, providers are required to indicate the applicable CPT (Current Procedural Terminology) procedure code listed in the following table with a zero-billed amount for the Beyfortus product administered. Providers must also include the **SL** modifier (State supplied vaccine) with the applicable CPT procedure code for Beyfortus obtained through the VFC (Vaccines for Children) Program.

Procedure Codes for Beyfortus
90380 (Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use)
90381 (Respiratory syncytial virus, monoclonal antibody, seasonal dose; 1 mL dosage, for intramuscular use)

To receive reimbursement for the administration of Beyfortus, providers must also indicate **one** of the following CPT administration codes on claims submitted to ForwardHealth:

- **96380** (Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection, with counseling by physician or other qualified health care professional)
- **96381** (Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection)

Providers may refer to the interactive maximum allowable fee schedules on the ForwardHealth Portal.

Topic #20082

Claims for Drugs Purchased Through the 340B Drug Pricing Program

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

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

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

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

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

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

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

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

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

Basis of Cost Determination and Submission Clarification Code

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

Professional Claim Modifier for Drugs Purchased Through the 340B Program

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

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

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

Topic #23640

Claims for IV Ketamine Infusion Therapy

Institutional Claims

Inpatient and outpatient hospital providers must submit institutional claims to ForwardHealth for fee-for-service members.

All components of the IV ketamine infusion therapy must be billed to the managed care entity (an HMO or MCO (managed care organization)) for managed care members whose program covers institutional claims.

For inpatient institutional claims, IV ketamine infusion therapy cannot be the primary reason for admitting the member for inpatient services.

Professional Claims

Claims for IV ketamine infusion therapy for MDD (major depressive disorder) with or without suicidality must be submitted according to current claim submission requirements for professional claims and physician-administered drugs.

The Physician-Administered Drugs Carve-Out Procedure Codes data table indicates the status of procedure codes considered under the physician-administered drugs carve-out policy.

UD Modifier for Drugs Purchased Through the 340B Program

The UD modifier must also be included with HCPCS (Healthcare Common Procedure Coding System) code J3490 for IV ketamine infusion therapy if the drug was purchased through the 340B (340B Drug Pricing) Program.

For example, providers who submit professional claims for ketamine under CPT (Current Procedural Terminology) code 96365 and HCPCS code J3490 with the U4 modifier for IV ketamine infusion therapy must also indicate the UD modifier with J3490.

National Drug Codes

NDCs (National Drug Codes) for physician-administered drugs must also be indicated on a professional claim. The NDC must be accompanied by:

- An NDC qualifier.
- A unit qualifier.
- The correct NDC units.

Providers must indicate the appropriate NDC of the drug that was dispensed. ForwardHealth will deny the claim if:

- An NDC is not indicated on the claim.
- The NDC is not produced by a drug manufacturer who participates in the federal Medicaid Drug Rebate Program.

Billing Example for IV Ketamine Infusion Therapy Drug Component

Providers are required to determine the appropriate procedure codes or units to bill based on the specific details of the treatment administered.

On a professional claim for IV ketamine infusion therapy for MDD with or without suicidality, the provider must indicate the correct number of units of the drug administered for both:

- The HCPCS code representing the drug.
- The NDC of the actual drug dispensed.

For example, a member receives a 35 mg dose of NDC 00409-2051-05 (Ketamine HCI 500 mg/5 mL vial) during their IV ketamine infusion therapy. The drug was not purchased through the 340B Program, so the UD modifier is not needed on the claim.

Providers would include HCPCS code J3490 with the U4 modifier to indicate 0.35 HCPCS billing units for the milliliter quantity for this claim. (The 0.35 billing units is equivalent to the example of 35 mg of ketamine given to the member.)

For NDC 00409-2051-05 (Ketamine HCI 500 mg/5 mL vial), the appropriate NDC unit of measurement is also in milliliters. Therefore, 0.35 NDC billing units would be indicated in the shaded area of Item Number 24A of the 1500 Health Insurance Claim Form ((02/2012) by entering N4 (which is the qualifier that indicates an NDC is being used). This is followed by the 11-digit NDC (include all leading zeros), then the two-letter abbreviation for the unit of measure, and the number of units. Do not leave any blank spaces between these elements.

Instructions on submitting a 1500 Health Insurance Claim Form with supplemental NDC information, is available in the 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12 on the National Uniform Claim Committee website.

Topic #6957

Copy Claims on the ForwardHealth Portal

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

Topic #5017

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

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

Topic #4997

Direct Data Entry of Professional and Institutional Claims on the Portal

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

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

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

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

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

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

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

- Type of bill
- Patient status
- Visit point of origin
- Visit priority
- Diagnosis codes
- Revenue codes
- Procedure codes
- HIPPS (Health Insurance Prospective Payment System) codes
- Modifiers

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

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

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

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

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

Topic #15957

Documenting and Billing the Appropriate National Drug Code

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

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

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

Topic #344

Electronic Claim Submission

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

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

Topic #641

Electronic Claim Submission for Physician Services

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

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

Provider Electronic Solutions Software

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

Topic #16937

Electronic Claims and Claim Adjustments With Other Commercial Health Insurance Information

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

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

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

Adjustments to Claims Submitted Prior to June 16, 2014

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

Topic #365

Extraordinary Claims

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

Topic #4837

HIPAA-Compliant Data Requirements

Procedure Codes

All fields submitted on paper and electronic claims are edited to ensure HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance before being processed. Compliant code sets include CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) procedure codes entered into all fields, including those fields that are

Not Required or Optional.

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

Provider Numbers

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

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

Topic #562

HMOs and Managed Care Organizations

Claims for services covered by the member's state-contracted HMO or MCO (managed care organization) should be submitted to the HMO or MCO provider services.

Topic #10837

Note Field for Most Claims Submitted Electronically

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

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

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

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

- Professional
- Institutional
- Dental

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

Claims Submitted via 837 Health Care Claim Transactions

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

Topic #561

Paper Claim Form Preparation and Data Alignment Requirements

Optical Character Recognition

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

The data alignment requirements do not apply to the Compound Drug Claim (F-13073 (04/2017)) form and the Noncompound Drug Claim (F-13072 (02/2025)) form.

Speed and Accuracy of Claims Processing

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

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

Handwritten Claims

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

Use Original Claim Forms

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

Use Laser or Ink Jet Printers

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

Alignment

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

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

The following sample claim forms demonstrate correct and incorrect alignment:

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

Clarity

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

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

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

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

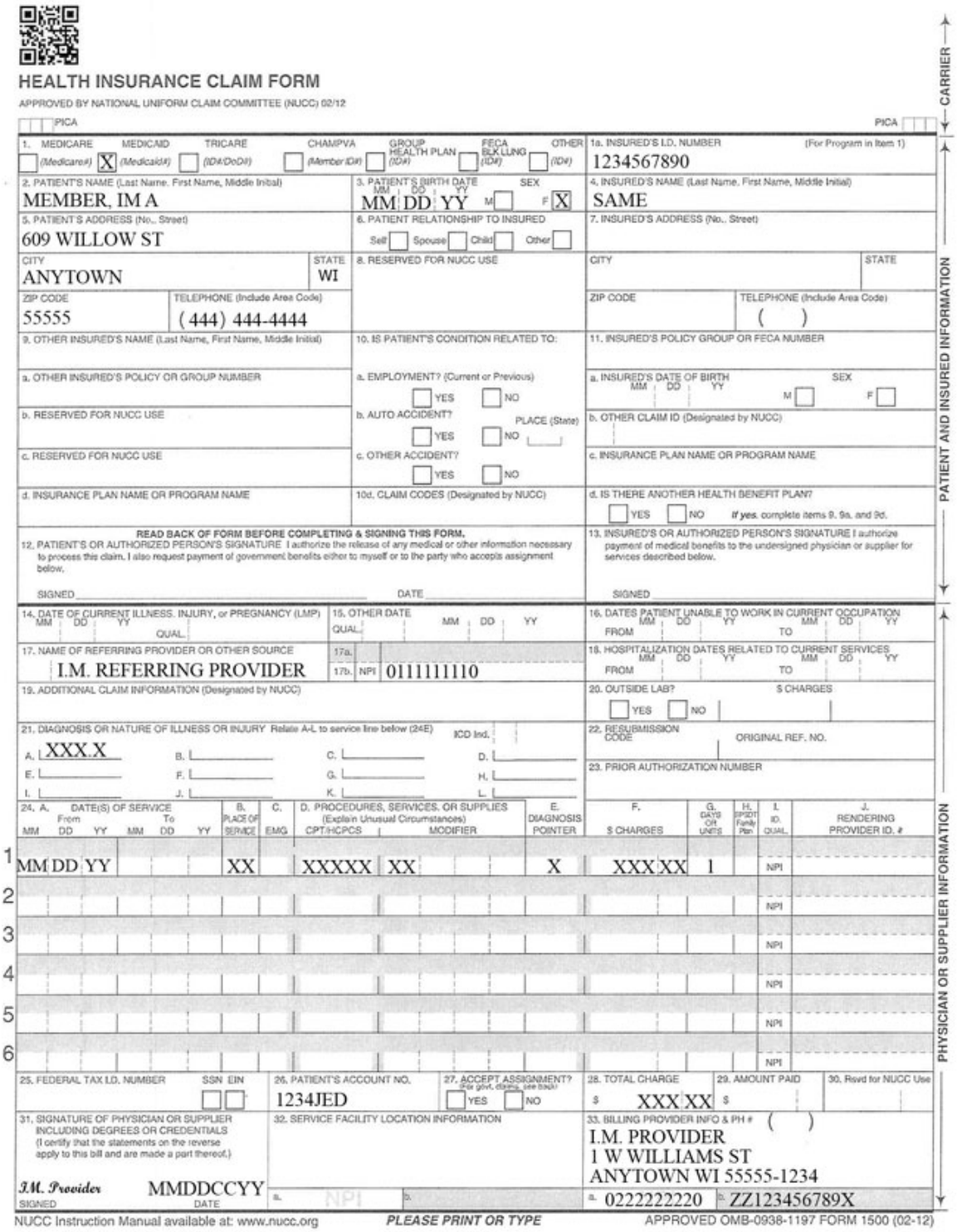
Staples, Correction Liquid, and Correction Tape

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

Additional Diagnosis Codes

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

Sample of a Correctly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

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

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

CITY: ANYTOWN | STATE: WI

8. RESERVED FOR NUCC USE

CITY: | STATE:

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

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

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

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: DATE:

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

SIGNED:

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

15. OTHER DATE QUAL. MM DD YY:

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

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

17a.

17b. NPI: 0111111110

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. XXX.X B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

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

25. FEDERAL TAX I.D. NUMBER SSN EIN:

26. PATIENT'S ACCOUNT NO.: 1234JED

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

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

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

I.M. Provider MMDDCCYY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

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

a. 0222222220 b. ZZ123456789X

CARRIER

PATIENT AND INSURED INFORMATION

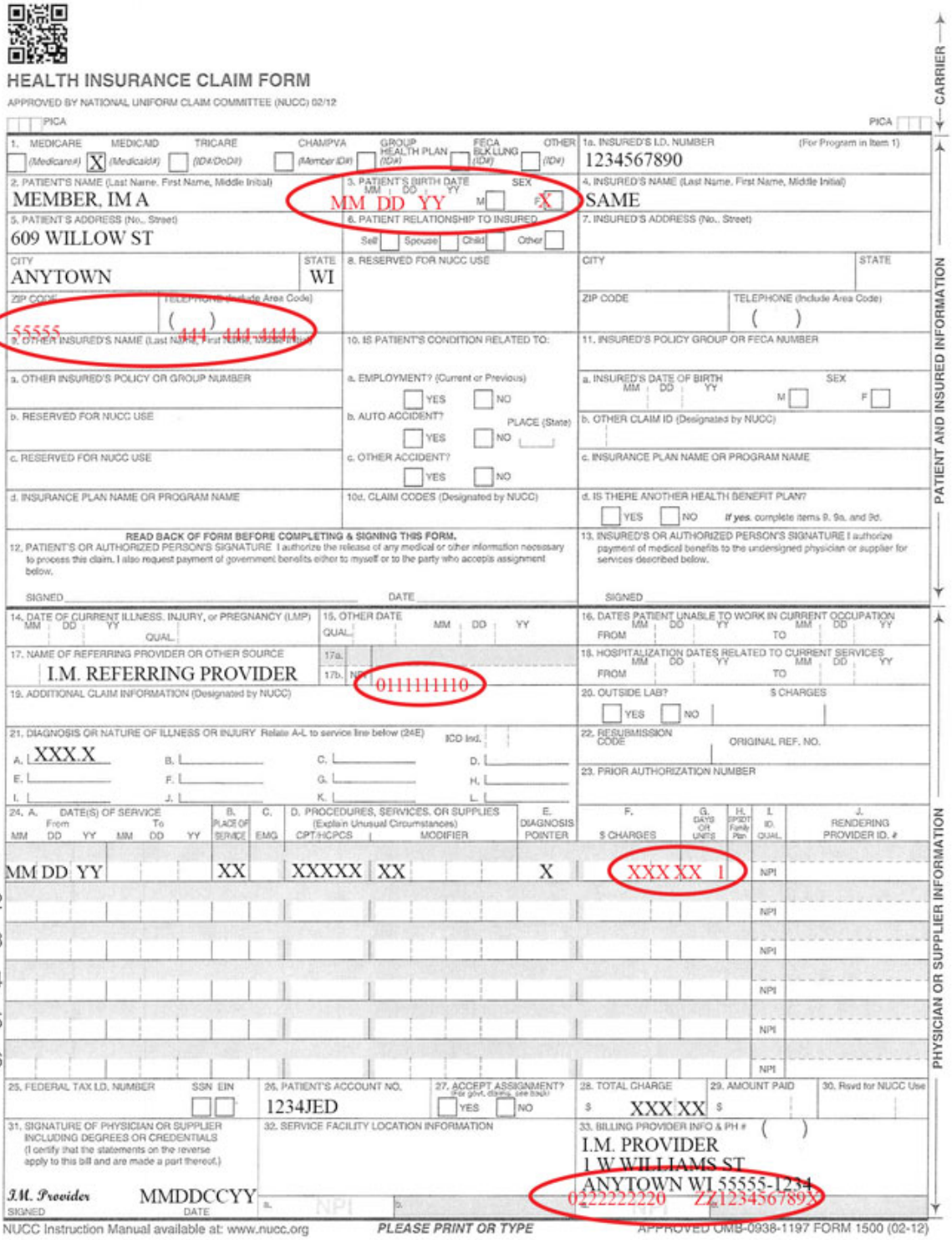
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Sample of an Incorrectly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

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

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

CITY: ANYTOWN | STATE: WI

8. RESERVED FOR NUCC USE

CITY | STATE

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

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

15. OTHER DATE QUAL. MM DD YY

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

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

17a.

17b. NPI 0111111110

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO | $ CHARGES

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

A. XXX.X B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. 1234JED

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

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

I.M. Provider MMDDCCYY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

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

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample of a Correctly Aligned UB-04 Claim Form

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

2

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

4 TYPE OF BILL XXX

5 FED. TAX NO. 01-2345678

6 STATEMENT COVERS PERIOD FROM MMDDCCYY THROUGH MMDDCCYY

7

8 PATIENT NAME a
b MEMBER, IM A

9 PATIENT ADDRESS a ON FILE
b c d e

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

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

38

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT
a b c d

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

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

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

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

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

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

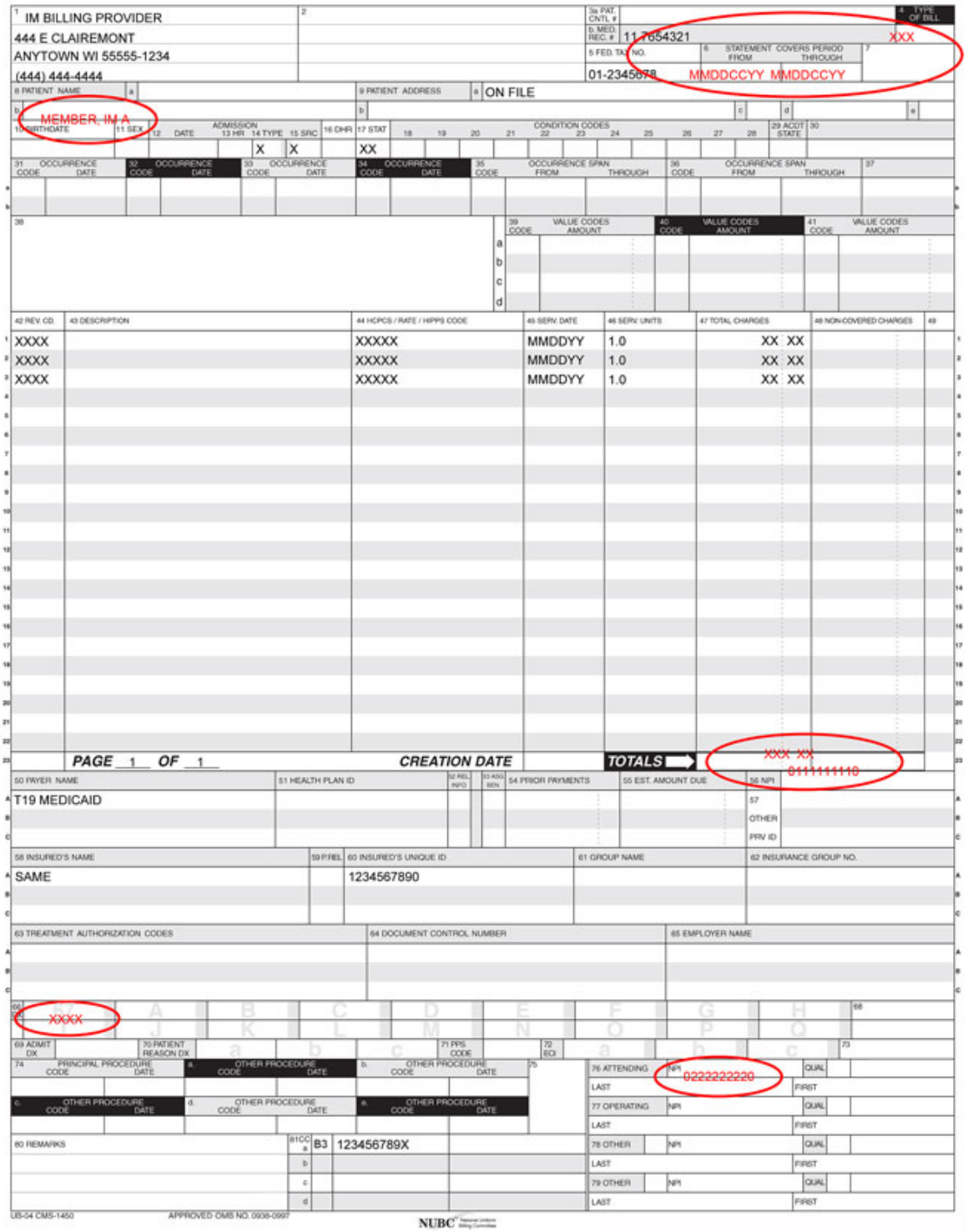
74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

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

80 REMARKS | 81CC a B3 123456789X
b c d

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

Sample of an Incorrectly Aligned UB-04 Claim Form



Topic #642

Paper Claim Submission

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

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

Obtaining the Claim Forms

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

Topic #22797

Payment Integrity Review Supporting Documentation

Providers are notified that an individual claim is subject to PIR (payment integrity review) through a message on the Portal when submitting claims. When this occurs, providers have seven calendar days to submit the supporting documentation that must be retained in the member's record for the specific service billed. This documentation must be attached to the claim. The following are examples of documentation providers may attach to the claim; however, this list is not exhaustive, and providers may submit any documentation available to substantiate payment:

- Case management or consultation notes
- Durable medical equipment or supply delivery receipts or proof of delivery and itemized invoices or bills
- Face-to-face encounter documentation
- Individualized plans of care and updates
- Initial or program assessments and questionnaires to indicate the start DOS (date of service)
- Office visit documentation
- Operative reports
- Prescriptions or test orders
- Session or service notice for each DOS
- Testing and lab results
- Transportation logs
- Treatment notes

Providers must attach this documentation to the claim at the time of, or up to seven days following, submission of the claim. A claim may be denied if the supporting documentation is not submitted. If a claim is denied, providers may submit a new claim with the required documentation for reconsideration. To reduce provider impact, claims reviewed by the OIG (Office of the Inspector General) will be processed as quickly as possible, with an expected average adjudication of 30 days.

Topic #4382

Physician-Administered Drug Claim Requirements

Deficit Reduction Act of 2005

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

ForwardHealth requires that NDCs be indicated on claims for all physician-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 physician-administered drugs will not receive federal funds for those claims.

ForwardHealth cannot claim a rebate or federal funds if the NDC submitted on a claim is incorrect or invalid or if an NDC is not indicated.

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

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

Less-Than-Effective Drugs

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

Claim Submission

Institutional Claims

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

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

Professional Claims

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

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

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

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

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

Medicare Crossover Claims

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

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

340B Providers

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

Explanation of Benefits Codes on Claims for Physician-Administered Drugs

Providers will receive an EOB (Explanation of Benefits) code on claims with a denied detail for a physician-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 physician-administered drug, he or she should correct and resubmit the claim for reimbursement.

Physician-Administered Claim Denials

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

Reconsideration of the denied drug claim may occur if the claim was denied with an EOB code and the drug therapy was due to the treatment for an acute condition. To submit a claim that was originally denied as a duplicate, pharmacies should complete and submit the Noncompound Drug Claim (F-13072 (02/2025)) form along with the Pharmacy Special Handling Request (F-13074 (04/2014)) form indicating the EOB code and requesting an override.

Physician-Administered Drugs Carve-Out Code Sets

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

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

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

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

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

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

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

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

Exemptions

Claims for drugs included in the cost of the procedure (for example, 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 (for example, hydration, catheter maintenance, TPN (total parenteral nutrition)) should continue to be reimbursed by the member's MCO. Providers should work with the member's MCO in these situations.

Additional Information

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

- CMS DRA information page
- NUBC (National Uniform Billing Committee)
- NUCC (National Uniform Claim Committee)

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

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

Topic #10237

Claims for Physician-Administered Drugs

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

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

1500 Health Insurance Claim Form

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

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

Providers should indicate the appropriate NDC of the drug that was dispensed that corresponds to the HCPCS procedure code on claims for physician-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 website for information about indicating NDCs on physician-administered drug claims submitted using the 837P transaction.

Direct Data Entry on the ForwardHealth Portal

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

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

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

Provider Electronic Solutions Software

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

Topic #10177

Prior Authorization Numbers on Claims

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

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

Topic #10637

Reimbursement Reduction for Most Paper Claims

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

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

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

The reimbursement reduction applies to the following paper claims:

- 1500 Health Insurance Claim Form ((02/12))
- UB-04 (CMS 1450) Claim Form
- Compound Drug Claim (F-13073 (04/2017)) form
- Noncompound Drug Claim (F-13072 (02/2025)) form

Exceptions to Paper Claim Reimbursement Reduction

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

- In-state emergency providers
- Out-of-state providers
- Medicare crossover claims
- Any claims that ForwardHealth requires additional supporting information to be submitted on paper, such as:
  - Hysterectomy claims must be submitted along with an Acknowledgment of Receipt of Hysterectomy Information (F-01160 (06/2013)) form.
  - Sterilization claims must be submitted along with a paper Consent for Sterilization (DMS-1000 (05/2025)) form.
  - Claims submitted to Timely Filing appeals must be submitted on paper with a Timely Filing Appeals Request (F-13047 (08/2015)) form.
  - In certain circumstances, drug claims must be submitted on paper with a Pharmacy Special Handling Request (F-13074 (04/2014)) form.
  - Claims submitted with four or more NDCs (National Drug Codes) for compound and noncompound drugs with specific and non-specific HCPCS (Healthcare Common Procedure Coding System) procedure codes.

Topic #1159

Routine Foot Care

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

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

reduced rate. Providers should submit a separate claim for each member seen on the same DOS.

Topic #21197

Select High Cost, Orphan, and Accelerated Approval Drugs

For the interim, select high cost, orphan, and accelerated approval drugs will be covered and reimbursed under the pharmacy benefit. When a noncompound drug is covered under the pharmacy benefit, providers may submit claims for the cost of the drug to ForwardHealth through one of the following methods:

- Real-time POS (point-of-sale) system using the NCPDP (National Council for Prescription Drug Programs) Telecommunication Standard
- ForwardHealth Portal
- PES (Provider Electronic Solutions) software
- Noncompound Drug Claim (F-13072 (02/2025)) form

Related physician and clinical services associated with the administration of the drug will be reimbursed separately based on existing coverage and reimbursement policy.

The Services Requiring Prior Authorization chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook contains clinical criteria for select high cost, orphan, and accelerated approval drugs that are identified in the Select High Cost, Orphan, and Accelerated Approval Drugs data table.

Pharmacy Direct Billing for Select High Cost, Orphan, and Accelerated Approval Drugs

To clarify, if a provider or facility obtains a drug that is specifically addressed in the Select High Cost, Orphan, and Accelerated Approval Drugs data table from a pharmacy provider, then the administering provider or facility may not bill for the cost of that drug because the pharmacy provider will bill for the cost of the drug.

It is the responsibility of the pharmacy provider to use appropriate management and packaging practices to ensure drug stability and integrity are maintained during drug shipment and delivery. Once the drug is in possession of the administering provider or facility, it is the responsibility of the administering provider or facility to use appropriate management and storage practices to ensure drug stability and integrity are maintained. If a drug is damaged prior to administration or is delivered but not administered to a member, ForwardHealth will not reimburse for the cost of the drug; it is the responsibility of the administering provider or facility to alert the pharmacy provider and the responsibility of the pharmacy provider to reverse their claim to ForwardHealth and work with the pharmaceutical company or administering provider or facility regarding payment for the damaged or wasted drug.

For the interim, select high cost, orphan, and accelerated approval drugs will be covered under the pharmacy benefit, but it is the responsibility of the health care provider to determine the medically appropriate setting for administration. Providers are required to comply with all relevant safety protocols when administering these drugs to ForwardHealth members.

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

Note: Select high cost, orphan, and accelerated approval drugs covered under the pharmacy benefit will not be covered as physician-administered drugs. When a high cost, orphan, or accelerated approval drug is covered under the pharmacy benefit, it will be reimbursed fee-for-service and MCOs (managed care organizations) will not be responsible for the cost of the drug, but

MCOs are still responsible for the physician and clinical services associated with the high cost, orphan, or accelerated approval drug.

Topic #18197

Sleep Medicine Testing

Facility-Based Sleep Studies and Polysomnography

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

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

Home-Based Sleep Studies

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

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

Topic #1251

Submitting Claims or Claim Adjustments for Separate Obstetric Care Components

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

Claims or Claim Adjustments for Antepartum Care Visits

Antepartum care includes the following:

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

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

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

- If the provider renders **three or fewer** antepartum care visits, the provider is required to submit a separate claim/claim detail (or adjustment) for **each** visit as follows:
  - Use the appropriate **E&M (evaluation and management) service code** representing the POS (place of service) and visit level.
  - Include modifier TH (Obstetrical treatment/services, prenatal or postpartum) with the E&M service code.
  - Indicate the quantity as "1.0."
  - Indicate the date of the visit as the DOS (date of service).
- If the provider renders **four to six** antepartum care visits, the provider is required to submit one claim/claim detail (or adjustment) covering **all** visits as follows:
  - Use the **antepartum care code** 59425 (Antepartum care only; 4-6 visits).
  - Indicate the quantity as "1.0."
  - Indicate the date of the last antepartum care visit as the DOS.
- If the provider renders **seven or more** antepartum care visits, the provider is required to submit one claim/claim detail (or adjustment) covering **all** visits as follows:
  - Use the **antepartum care code** 59426 (Antepartum care only; 7 or more visits).
  - Indicate the quantity as "1.0."
  - Indicate the date of the last antepartum care visit as the DOS.

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

The table below summarizes these guidelines.

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

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

Claims or Claim Adjustments for Delivery

Delivery includes the following:

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

Multiple Deliveries

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

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

Claims or Claim Adjustments for Postpartum Care

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

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

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

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

Claims or Claim Adjustments for Delivery and Postpartum Care

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

Topic #15977

Submitting Multiple National Drug Codes per Procedure Code

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

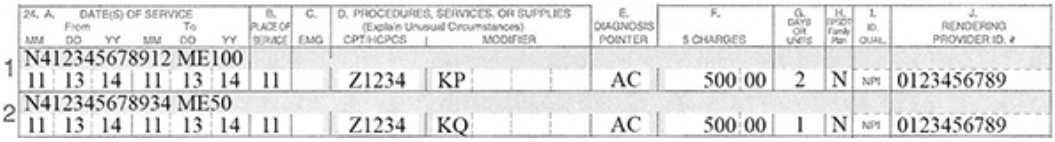
Claim Submission Instructions for Claims With Two or Three National Drug Codes

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

For example, if a provider administers 150 mg of XYZ drug, and a 100 mg vial and a 50 mg vial were used, then the NDC from each vial must be submitted on the claim. Although the vials have different NDCs, the drug has one procedure code, Z1234. In this example, the same procedure code would be reported on two details of the claim and paired with different NDCs.

Procedure Code	NDC	NDC Description
Z1234	12345-6789-12	XYZ drug—100 mg
Z1234	12345-6789-34	XYZ drug—50 mg

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



	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	N412345678912 ME100											
	11 13 14	11 13 14	11		Z1234	KP	AC	500 00	2	N	NPI	0123456789
2	N412345678934 ME50											
	11 13 14	11 13 14	11		Z1234	KQ	AC	500 00	1	N	NPI	0123456789

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

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

Procedure Code	NDC	NDC Description
J3490	11111-2222-33	ABC drug—1 mg
J3490	12345-6789-56	XYZ drug—125 mg
J3490	44444-5555-66	PRQ drug—50 ml

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

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	N411111222233 ME1											
	11 13 14	11 13 14	11		J3490	KP	AC	500 00	1	N	NPI	0123456789
2	N412345678956 ME125											
	11 13 14	11 13 14	11		J3490	KQ	AC	500 00	1	N	NPI	0123456789
3	N444444555566 ML50											
	11 13 14	11 13 14	11		J3490		AC	500 00	1	N	NPI	0123456789

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

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

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

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

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

Topic #4817

Submitting Paper Attachments With Electronic Claims

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

Paper attachments that go with electronic claim transactions must be submitted with the Claim Form Attachment Cover Page (F-13470 (03/2023)). Providers are required to indicate an ACN (attachment control number) for paper attachment(s) submitted with electronic claims. (The ACN is an alphanumeric entry between two and 80 digits assigned by the provider to identify the attachment.) The ACN must be indicated on the cover page so that ForwardHealth can match the paper attachment(s) to the correct electronic claim.

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

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

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

This does not apply to compound and noncompound claims.

Topic #15317

Surgical Procedures Billed on Professional Claims

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

Topic #11677

Uploading Claim Attachments via the Portal

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

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

Claim Types

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

- Professional
- Institutional
- Dental

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

Document Formats

Providers are able to upload documents in the following formats:

- JPEG (.jpg or .jpeg)
- PDF (.pdf)
- Rich Text Format (.rtf)
- Text File (.txt)
- OrthoCAD (.3dm) and 3Shape Ortho System (.dcm, .stl, and .ply) (for dental providers)

Make sure files are stored with the correct extension:

- JPEG files are stored with a ".jpg" or ".jpeg" extension.
- PDF files are stored with a ".pdf" extension.
- Rich text format files are stored with an ".rtf" extension.
- Text files are stored with a ".txt" extension.
- Dental OrthoCAD files are stored with a ".3dm" extension.
- Dental 3Shape Ortho System files are stored with ".dcm", ".stl", or ".ply" extensions.

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

Uploading Claim Attachments

Claims Submitted by Direct Data Entry

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

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

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

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

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

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

Topic #3564

Vaccines

Providers are required to indicate both the vaccine product and vaccine administration CPT (Current Procedural Terminology) codes on all claims. Providers are required to indicate their usual and customary charge for the service with the procedure code. When vaccine product obtained through the VFC (Vaccines for Children) program is administered to members 18 years of age or younger, providers must also include the SL modifier (State-supplied vaccine).

Timely Filing Appeals Requests

Topic #549

Requirements

When a claim or adjustment request meets one of the exceptions to the submission deadline, the provider is required to mail ForwardHealth a Timely Filing Appeals Request (F-13047 (08/2015)) form with a paper claim or an Adjustment/Reconsideration Request (F-13046 (02/2025)) form to override the submission deadline. If claims or adjustment requests are submitted electronically, the entire amount of the claim will be recouped.

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

Topic #551

Resubmission

Decisions on Timely Filing Appeals Requests (F-13047 (08/2015)) cannot be appealed. Providers may resubmit the claim to Timely Filing if both of the following occur:

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

Topic #744

Submission

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

- A properly completed Timely Filing Appeals Request (F-13047 (08/2015)) form for each claim and each adjustment to allow for documentation of individual claims and adjustments submitted to ForwardHealth
- A legible claim or Adjustment/Reconsideration Request (F-13046 (02/2025)) form
- All required documentation as specified for the exception to the submission deadline
- A properly completed Explanation of Medical Benefits form for paper claims and paper claim adjustments where other health insurance sources are indicated

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

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

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

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

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

	¡ Temporary Identification Card for Express Enrollment in BadgerCare Plus ¡ Temporary Identification Card for Express Enrollment in Family Planning Only Services ¡ The response received through Wisconsin's EVS (Enrollment Verification System) from a commercial eligibility vendor ¡ The transaction log number received through WiCall ¡ The enrollment tracking number received through the ForwardHealth Portal	

ForwardHealth Reconsideration or Recoupment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when ForwardHealth reconsiders a previously processed claim. ForwardHealth will initiate an adjustment on a previously paid claim.	If a subsequent provider submission is required, the request must be submitted within 90 days from the date of the RA (Remittance Advice) message. Include the following documentation as part of the request: ¡ A copy of the RA message that shows the ForwardHealth-initiated adjustment ¡ A copy of the Explanation of Medical Benefits form, if applicable	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Retroactive Enrollment for Persons on General Relief		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when the income maintenance or tribal agency requests a return of a GR (general relief) payment from the provider because a member has become retroactively enrolled for Wisconsin Medicaid or BadgerCare Plus.	To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the member's enrollment information. Include the following documentation as part of the request: ¡ A copy of the Explanation of Medical Benefits form, if applicable **And** ¡ GR retroactive enrollment indicated on the claim **Or** ¡ A copy of the letter received from the income maintenance or tribal agency	ForwardHealth GR Retro Eligibility Ste 50 313 Blettner Blvd Madison WI 53784

Medicare Denial Occurs After the Submission Deadline

Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when claims submitted to Medicare (within 365 days of the DOS) are denied by Medicare after the 365-day submission deadline. A waiver of the submission deadline will not be granted when Medicare denies a claim for one of the following reasons: - The charges were previously submitted to Medicare. - The member name and identification number do not match. - The services were previously denied by Medicare. - The provider retroactively applied for Medicare enrollment and did not become enrolled.	To receive consideration, the request must be submitted within 90 days of the Medicare processing date. Include the following documentation as part of the request: - A copy of the Medicare remittance information - A copy of the Explanation of Medical Benefits form, if applicable	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Refund Request from an Other Health Insurance Source

Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when an other health insurance source reviews a previously paid claim and determines that reimbursement was inappropriate.	To receive consideration, the request must be submitted within 90 days from the date of recoupment notification. Include the following documentation as part of the request: - A copy of the recoupment notice - An updated Explanation of Medical Benefits form, if applicable Note: When the reason for resubmitting is due to Medicare recoupment, ensure that the associated Medicare disclaimer code (M-7 or M-8) is included on the updated Explanation of Medical Benefits form.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Retroactive Member Enrollment into Medicaid

Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when a claim cannot be submitted within the submission deadline due to a delay in the	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	ForwardHealth Timely Filing Ste 50

determination of a member's retroactive enrollment.	must be indicated by selecting Retroactive member enrollment for ForwardHealth (attach appropriate documentation for retroactive period, if available) box on the Timely Filing Appeals Request (F-13047 (08/15)) form.	313 Blettner Blvd Madison WI 53784

Coordination of Benefits

2

Archive Date:10/01/2026

Coordination of Benefits:Commercial Health Insurance

Topic #595

Assignment of Insurance Benefits

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

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

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

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

Topic #844

Claims for Services Denied by Commercial Health Insurance

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

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

Topic #598

Commercial Fee-for-Service

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

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

Topic #601

Definition of Commercial Health Insurance

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

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

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

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

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

Topic #602

Discounted Rates

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

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

Topic #596

Exhausting Commercial Health Insurance Sources

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

Step 1. Determine if the Member Has Commercial Health Insurance

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

If the member disputes the information as it is indicated in the EVS, the provider should submit a real-time Other Coverage Discrepancy Report via the ForwardHealth Portal or submit a completed Commercial Other Coverage Discrepancy Report (F-01159 (04/2017)) form. Unless the service does not require other health insurance billing, the provider should allow at least two weeks before proceeding to Step 2.

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

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

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

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

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

Step 3. Identify Assignment of Commercial Health Insurance Benefits

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

The provider should proceed in one of the following ways:

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

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

Step 4. Bill Commercial Health Insurance and Follow Up

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

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

Step 5. Submit Claim to ForwardHealth

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

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

Topic #18497

Explanation of Medical Benefits Form Requirement

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

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

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

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

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

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

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

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

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

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

Topic #263

Members Unable to Obtain Services Under Managed Care Plan

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

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

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

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

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

Topic #604

Non-Reimbursable Commercial Health Insurance Services

Providers are not reimbursed for the following:

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

Topic #605

Other Insurance Indicators

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

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

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

Code	Description
OI-P	PAID in part or in full by commercial health insurance, and/or was applied toward the deductible,

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

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

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

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

Documentation Requirements

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

Topic #603

Services Not Requiring Commercial Health Insurance Billing

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

- Case management services
- CCS (Comprehensive Community Services)
- Crisis Intervention services
- CRS (Community Recovery Services)
- CSP (Community Support Program) services
- Family planning services
- In-home mental health/substance abuse treatment services for children (HealthCheck Other Services) rendered by providers at the less than bachelor's degree level, bachelor's degree level, QTT (qualified treatment trainee) level, or

certified psychotherapist level
- Personal care services
- PNCC (prenatal care coordination) services
- Preventive pediatric services
- SMV (specialized medical vehicle) services

Topic #769

Services Requiring Commercial Health Insurance Billing

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

- Ambulance services, if provided as emergency services
- Anesthetist services
- Audiology services, unless provided in a nursing home or SNF (skilled nursing facility)
- Behavioral treatment
- Blood bank services
- Chiropractic services
- Dental services
- DME (durable medical equipment) (rental or purchase), prosthetics, and hearing aids if the billed amount is over $10 per item
- Home health services (excluding PC (personal care) services)
- Hospice services
- Hospital services, including inpatient or outpatient
- Independent nurse, nurse practitioner, or nurse midwife services
- Laboratory services
- Medicare-covered services for members who have Medicare and commercial health insurance
- In-home mental health/substance abuse treatment services for children (HealthCheck Other Services) rendered by providers at the master's degree level, doctoral level, and psychiatrist level
- Outpatient mental health/substance abuse services
- Mental health/substance abuse day treatment services, including child and adolescent day treatment
- Narcotic treatment services
- PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services, unless provided in a nursing home or SNF
- Physician assistant services
- Physician services, including surgery, surgical assistance, anesthesiology, or any service to a hospital inpatient (however, physician services provided to a woman whose primary diagnosis indicates a high-risk pregnancy do not require commercial health insurance billing)
- Pharmacy services for members with verified drug coverage
- Podiatry services
- PDN (private duty nursing) services
- Radiology services
- RHC (rural health clinic) services
- Skilled nursing home care, if any DOS (date of service) is within 120 days of the date of admission; if benefits greater than 120 days are available, the nursing home is required to continue to bill for them until those benefits are exhausted
- Vision services over $50, unless provided in a home, nursing home, or SNF

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

- Ophthalmology services

- Optometrist services

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

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

ForwardHealth has identified services requiring Medicare Advantage billing.

Medicare

Topic #664

Acceptance of Assignment

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

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

Topic #666

Claims Denied for Errors

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

Topic #668

Claims Processed by Commercial Health Insurance That Is Secondary to Medicare

If a crossover claim is also processed by commercial health insurance that is secondary to Medicare (for example, Medicare supplemental), the claim will not be forwarded to ForwardHealth. After the claim has been processed by the commercial health insurance, the provider should submit a provider-submitted crossover claim to ForwardHealth with the appropriate other insurance indicator or Explanation of Medical Benefits form, as applicable.

Topic #670

Claims That Do Not Require Medicare Billing

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

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

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

Topic #704

Claims That Fail to Cross Over

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

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

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

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

Topic #667

Claims for Services Denied by Medicare

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

Topic #671

Crossover Claims

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

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

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

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

- Automatic crossover claims

- Provider-submitted crossover claims

Automatic Crossover Claims

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

Claims will be forwarded if the following occur:

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

Providers are advised to wait 30 days before billing for claims submitted to Medicare to allow time for the automatic crossover process to complete. If automatic crossover claims do not appear on the ForwardHealth and/or the MCO (managed care organization)'s RA (Remittance Advice) after 30 days of the Medicare processing date, providers are required to resubmit the claim directly to ForwardHealth or the MCO using the NPI (National Provider Identifier) that was reported to ForwardHealth as the primary NPI.

If the service is covered by the MCO, the ForwardHealth RA will indicate EOB (Explanation of Benefits) code 0287 (Member is enrolled in a State-contracted managed care program). If the service is covered on a fee-for-service basis, the MCO RA will indicate that the service is not covered. If the crossover claim is submitted without error, the responsible entity (either ForwardHealth or the MCO) will process the claim to a payable status.

Provider-Submitted Crossover Claims

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

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

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

- The NPI that ForwardHealth has on file for the provider
- The taxonomy code that ForwardHealth has on file for the provider
- The ZIP+4 code that corresponds to the practice location address on file with ForwardHealth

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

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

- Paper claim form

Topic #672

Definition of Medicare

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

Medicare coverage is divided into four parts:

- Part A (Hospital Insurance). Part A helps to pay for medically necessary services, including inpatient hospital services, services provided in critical access hospitals (for example, 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 (Supplemental Medical Insurance). Part B helps to pay for medically necessary services, including physician services, outpatient hospital services, and some other services that Part A does not cover (such as PT (physical therapy) services, OT (occupational therapy) services, and some home health services).
- Part C (Medicare Advantage). A commercial health plan that acts for Medicare Parts A and B, and sometimes Medicare Part D, for all Medicare covered services except hospice. Medicare Part A continues to provide coverage for hospice services. There are limitations on coverage outside of the carrier's provider network.
- Part D (drug benefit).

Topic #684

Dual Eligibles

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

Dual eligibles may receive coverage for the following:

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

Topic #669

Exhausting Medicare Coverage

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

Adjustment Request for Crossover Claim

The provider may submit a paper or electronic adjustment request. If submitting a paper Adjustment/Reconsideration Request (F-13046 (02/2025)) form, the provider should complete and submit the Explanation of Medical Benefits form, as applicable.

Provider-Submitted Crossover Claim

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

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

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

- For electronic claims, indicate the Medicare payment.
- For paper claims, complete the Explanation of Medical Benefits form.

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

- Refrain from submitting the claim to ForwardHealth until after the claim has been processed by the commercial health insurance.
- Indicate the appropriate other insurance indicator on the claim or the Explanation of Medical Benefits form, as applicable.

* In this situation, a timely filing appeals request may be submitted if the services provided are beyond the claims submission deadline. The provider is required to indicate "retroactive enrollment" on the provider-submitted crossover claim and submit the claim with the Timely Filing Appeals Request (F-13047 (08/2015)) form and Explanation of Medical Benefits form, as applicable. The provider is required to submit the timely filing appeals request within 180 days from the date the backdated enrollment was added to the member's file.

Claim for Services Denied by Medicare

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

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

Crossover Claim Previously Reimbursed

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

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

In these situations, the provider should proceed as follows:

- Refund or adjust Medicaid payments for services previously reimbursed by Wisconsin Medicaid.

- Bill Medicare for the services and follow ForwardHealth's procedures for submitting crossover claims.

Topic #687

Medicare Advantage

Medicare services may be provided to dual eligibles or QMB-Only (Qualified Medicare Beneficiary-Only) members on a fee-for-service basis or through a Medicare Advantage Plan. Medicare Advantage Plans have a special arrangement with the federal CMS (Centers for Medicare and Medicaid Services) and agree to provide all Medicare benefits to Medicare beneficiaries for a fee. Providers may contact Medicare for a list of Medicare Advantage Plans in Wisconsin and the insurance companies with which they are associated.

ForwardHealth has identified services requiring Medicare Advantage billing.

Paper Crossover Claims

Providers are required to complete and submit an Explanation of Medical Benefits form, along with provider-submitted paper crossover claims for services provided to members enrolled in a Medicare Advantage Plan.

Reimbursement Limits

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

Topic #20677

Medicare Cost

Providers are required to bill the following services to the Medicare Cost Plan before submitting claims to ForwardHealth if the member was enrolled in the Medicare Cost Plan at the time the service was provided:

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

Providers who are not within the member's Medicare Cost network and are not providing an emergency service or Medicare-allowed service with a referral may submit a claim to traditional Medicare Part A or Medicare Part B for the Medicare-allowed service prior to billing ForwardHealth.

Topic #688

Medicare Disclaimer Codes

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

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

When submitting a claim for a covered service that was denied by Medicare, providers should resubmit the claim **directly** to ForwardHealth using the appropriate Medicare disclaimer code on the claim or the Explanation of Medical Benefits form, as applicable.

Code	Description
M-7	Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, 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 enrolled in Medicare Part A. - The member is eligible for Medicare Part A. - The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or exhausted benefits. **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 enrolled in Medicare Part B. - The member is eligible for Medicare Part B. - The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or exhausted benefits.
M-8	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 enrolled in Medicare Part A. - The member is eligible for Medicare Part A. - The service is usually covered by Medicare Part A but not in this circumstance (for example, member's diagnosis). **For Medicare Part B, use M-8 in the following instances (all three criteria must be met):** - The provider is identified in ForwardHealth files as enrolled in Medicare Part B. - The member is eligible for Medicare Part B. - The service is usually covered by Medicare Part B but not in this circumstance (for example, member's diagnosis).

Documentation Requirements

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

Topic #8457

Medicare Late Fees

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

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

Resubmitting Medicare Crossover Claims with Late Fees

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

Paper Claim Submissions

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

Electronic Claim Submissions

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

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

- Billed Amount: $110
- Allowed Amount: $100
- Coinsurance: $20
- Late Fee: $5
- Paid Amount: $75

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 to the paid amount of $75 for a total of $80. The claim should report the Medicare paid amount as $80.

Topic #689

Medicare Provider Enrollment

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

Services for Dual Eligibles

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

- They provide a Medicare Part A service to a dual eligible.
- They can be enrolled in Medicare.

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

Services for Qualified Medicare Beneficiary-Only Members

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

Topic #690

Medicare Retroactive Eligibility — Member

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

Topic #895

Modifier for Catastrophe/Disaster-Related Crossover Claims

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

Topic #4957

Provider-Submitted Crossover Claims

A provider-submitted crossover claim is a Medicare-allowed claim that a provider directly submits to ForwardHealth when the

Medicare claim did not automatically crossover to ForwardHealth.

Electronic Professional Crossover Claims

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

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

Paper Professional Crossover Claims

All paper provider-submitted crossover claims submitted on the 1500 Health Insurance Claim Form ((02/12)) require a provider signature and date in Item Number 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.

In addition, when submitting a paper provider-submitted crossover claim, providers are required to complete and submit an Explanation of Medical Benefits form, as applicable.

Topic #692

Qualified Medicare Beneficiary-Only Members

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

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

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

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

Topic #686

Reimbursement for Crossover Claims

Professional Crossover Claims

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

Total payment for a Medicare Part B-covered service (for example, any amount paid by other health insurance sources, any copay 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 copay of a Medicare Part B-covered service is the lesser of the following:

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

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

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

Outpatient Hospital Crossover Claims

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

Inpatient Hospital Services

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

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

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

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

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

Medicare coinsurance, copay and deductible	$0	$200	$500
Medicaid payment	$0	$0	$250

Nursing Home Crossover Claims

Medicare deductibles, coinsurance, and copays are paid in full.

Community Health Center and Tribal Federally Qualified Health Center Crossover Claims

CHC (Community health center) and Tribal FQHC (federally qualified health center) encounters subject to PPS (prospective payment system) and AIR (all-inclusive rate) reimbursement are carved out of (not included in) Medicare Crossover coverage.

Topic #4977

Rendering Provider on Professional Crossover Claims

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

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

This ForwardHealth requirement is inconsistent with the instructions in the 837P Implementation Guide; however, the federal CMS (Centers for Medicare & Medicaid Services) has acknowledged that health plans may need the billing provider taxonomy in order to accurately process claims.

Topic #770

Services Requiring Medicare Advantage Billing

Providers are required to bill the following services to the Medicare Advantage Plan before submitting claims to ForwardHealth:

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

- Physician services

Providers who are not within the member's Medicare Advantage network and are not providing an emergency service or Medicare-allowed service with a referral are required to refer the member to a provider within their network.

ForwardHealth has identified services requiring commercial health insurance billing.

Other Coverage Information

Topic #4940

After Reporting Discrepancies

After receiving a Commercial Other Coverage Discrepancy Report (F-01159 (04/2017)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/2018)) form, ForwardHealth confirms the information and updates the member files.

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

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

Topic #4941

Coverage Discrepancies

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

Topic #609

Insurance Disclosure Program

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

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

Topic #610

Maintaining Accurate and Current Records

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

- Insurance Disclosure program
- Providers who submit an Commercial Other Coverage Discrepancy Report (F-01159 (04/2017)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/2018)) form

- Member certifying agencies
- Members

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

Topic #4942

Reporting Discrepancies

Providers are encouraged to report discrepancies to ForwardHealth by submitting the Commercial Other Coverage Discrepancy Report (F-01159 (04/2017)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/2018)) form. Providers are asked to complete the form in the following situations:

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

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

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

Provider-Based Billing

Topic #660

Purpose of Provider-Based Billing

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

Topic #658

Questions About Provider-Based Billing

For questions about provider-based billing claims that are within the 120-day limit, providers may call the Coordination of Benefits Unit at 608-243-0676. Providers may fax the corresponding Provider-Based Billing Summary to 608-221-4567 at the time of the telephone call.

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

Topic #661

Receiving Notification

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

- A notification letter.
- A Provider-Based Billing Summary. The summary lists each claim from which a provider-based billing claim was created. The summary also indicates the corresponding primary payer for each claim and necessary information for providers to review and handle each claim.

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

Accessing Provider-Based Billing Summary Reports

Providers can retrieve provider-based billing summary reports through the Portal by logging in to their secure provider Portal account. Once logged in, providers can click the Provider Based Bills (PBB) link located in the Quick Links box of the Providers area of the Portal to access the Provider Based Billing page. This page has links for the provider to download provider-based summary reports in .csv or .pdf format.

Refer to the Provider-Based Billing Retrieval User Guide for step-by-step instructions on how to access the Provider Based Billing page and download provider-based summary reports.

Note: ForwardHealth also sends the paper provider-based billing summary report to the provider's "mail to" address on file in the Portal.

The provider-based billing process runs monthly on the first full weekend of every month, and files are available once the process is completed.

Topic #659

Responding to ForwardHealth After 120 Days

If a response is not received within 120 days, the amount originally paid by BadgerCare Plus or Wisconsin Medicaid will be withheld from future payments. This is not a final action. To receive payment after the original payment has been withheld, providers are required to submit the required documentation to the appropriate address as indicated in the following tables. For DOS (dates of service) that are within claims submission deadlines, providers should refer to the first table. For DOS that are beyond claims submission deadlines, providers should refer to the second table.

Within Claims Submission Deadlines		
Scenario	**Documentation Requirement**	**Submission Address**
The provider discovers through the EVS (Enrollment Verification System) that ForwardHealth has removed or end-dated the other health insurance coverage from the member's file.	A claim according to normal claims submission procedures (do **not** use the provider-based billing summary).	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784
The provider discovers that the member's other coverage information (that is, enrollment dates) reported by the EVS is invalid.	• A Commercial Other Coverage Discrepancy Report (F-01159 (04/2017)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/2018)) form. • A claim according to normal claims submission procedures after verifying that the member's other coverage information has been updated by using the EVS (do **not** use the provider-based billing summary).	Send the Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form to the address indicated on the form. Send the claim to the following address: ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	• A claim according to normal claims submission procedures (do **not** use the provider-based billing summary). • The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784

	◦ The amount received from the other health insurance source on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	
The other health insurance source denies the provider-based billing claim.	◦ A claim according to normal claims submission procedures (do **not** use the provider-based billing summary). ◦ The appropriate other insurance indicator or Medicare disclaimer code on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784
The commercial health insurance carrier does not respond to an initial **and** follow-up provider-based billing claim.	◦ A claim according to normal claims submission procedures (do **not** use the provider-based billing summary). ◦ The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784

Beyond Claims Submission Deadlines		
Scenario	**Documentation Requirement**	**Submission Address**
The provider discovers through the EVS that ForwardHealth has removed or end-dated the other health insurance coverage from the member's file.	◦ A claim (do **not** use the provider-based billing summary). ◦ A Timely Filing Appeals Request (F-13047 (08/2015)) form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The provider discovers that the member's other coverage information (that is, enrollment dates) reported by the EVS is invalid.	◦ A Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form. ◦ **After** using the EVS to verify that the member's other coverage information has been updated, include both of the following: ▪ A claim (do **not** use the provider-based billing summary.)	Send the Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form to the address indicated on the form. Send the timely filing appeals request to the following address:

	¡ A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The commercial health insurance carrier reimburses or partially reimburses the provider-based billing claim.	ı A claim (do **not** use the provider-based billing summary). ı Indicate the amount received from the commercial health insurance on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. ı A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The other health insurance source denies the provider-based billing claim.	ı A claim. ı The appropriate other insurance indicator or Medicare disclaimer code on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. ı A Timely Filing Appeals Request form according to normal timely filing appeals procedures. ı The Provider-Based Billing Summary. ı 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.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

	• The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.	
The commercial health insurance carrier does not respond to an initial and follow-up provider-based billing claim.	• A claim (do **not** use the provider-based billing summary). • The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Topic #662

Responding to ForwardHealth Within 120 Days

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

- The provider discovers through the EVS (Enrollment Verification System) that ForwardHealth has removed or end-dated 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 end-dated 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 (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.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567

	¡ A printed page from an enrollment website containing the member's correct other coverage information.	
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	ı The Provider-Based Billing Summary. ı A copy of the remittance information received from the other health insurance source. ı The DOS (date of service), other health insurance source, billed amount, and procedure code indicated on the other insurer's remittance information must match the information on the Provider-Based Billing Summary. ı A copy of the Explanation of Medical Benefits form, as applicable. Note: In this situation, ForwardHealth will initiate an adjustment if the amount of the other health insurance payment does not exceed the allowed amount (even though an adjustment request should not be submitted). However, providers (except nursing home and hospital providers) may issue a cash refund. Providers who choose this option should include a refund check but should not use the Claim Refund form.	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.	ı The Provider-Based Billing Summary. ı 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	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567

	documentation from the other health insurance source that indicates the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage. ¡ A copy of the Explanation of Medical Benefits form, as applicable. ı The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.	
The other health insurance source fails to respond to the initial **and** follow-up provider-based billing claim.	ı The Provider-Based Billing Summary. ı Indication that no response was received by the other health insurance source. ı Indication of the dates that the initial and follow-up provider-based billing claims were submitted to the other health insurance source.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567

Topic #663

Submitting Provider-Based Billing Claims

For each provider-based billing claim, the provider is required to send a claim to the appropriate other health insurance source. The provider should add all information required by the other health insurance source to the claim. The providers should also attach additional documentation (for example, Medicare's remittance information) if required by the other health insurance source.

Reimbursement for Services Provided for Accident Victims

Topic #657

Billing Options

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

- Civil liabilities (for example, injuries from an automobile accident)
- Worker's compensation

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

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

Topic #829

Points of Consideration

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

Time

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

Costs

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

Topic #826

Seeking Payment From Settlement

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

Topic #827

Submitting Claims to ForwardHealth

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

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

Covered and Noncovered Services

3

Archive Date:10/01/2026

Covered and Noncovered Services:Clozapine Management

Topic #2604

An Overview

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

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

Clozapine management is covered for members enrolled in BadgerCare Plus and Medicaid.

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

Topic #7277

Clozapine Coverage for Dual Eligibles

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

Topic #2606

Components

The following components are part of the clozapine management service and must be provided, as needed, by a provider acting within the scope of their practice:

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

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

  - The member has taken clozapine continually for six months.
  - The weekly WBC count has remained stable at greater than or equal to 3,500/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-enrolled laboratory.

- Obtain the blood test results in a timely fashion.
- Ensure that abnormal blood test results are reported in a timely fashion to the provider dispensing the member's clozapine.
- Ensure that the member receives medications as scheduled and that the member stops taking medication when a blood test is abnormal, if this decision is made, and receives any 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 provider is responsible for ensuring that all individuals having direct contact with the member in providing clozapine management services have sufficient training and education. These individuals must be able to recognize the signs and symptoms of mental illness, the side effects from drugs used to treat mental illness, and when changes in the member's level of functioning need to be reported to a physician or registered nurse.
- Following the record keeping requirements for clozapine management.

Topic #2607

Conditions for Coverage

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

- A prescription for the clozapine management services in writing if any of the components of clozapine management are provided by the physician or by individuals who are collaborating with 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 provider acting within the scope of their practice has provided the required components of clozapine management.

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

Topic #2608

Member Diagnosis

Clozapine is appropriate for members with an ICD (International Classification of Diseases) diagnosis of a F20.0–F20.9 (Schizophrenia) or F25.0–F25.9 (Schizoaffective disorders) **and** who have a documented history of failure with at least two psychotropic drugs. Lithium carbonate may not be one of the two failed drugs. Reasons for the failure may include:

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

Topic #2609

Record Keeping Requirements

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

- A cover sheet identifying the member, including the following information:
  - Member's Medicaid identification number.
  - Member's name.
  - Member's current address.
  - Name, address, and telephone number of the primary medical provider (if different from the prescriber).
  - Name, address, and telephone number of the dispensing provider from whom the member is receiving clozapine tablets.
  - Address and telephone number of other locations at which the client may be receiving a blood draw on his or her own.
  - Address and telephone number where the member can often be contacted.
- A care plan indicating the manner in which the provider ensures that the covered services are provided (for example, 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 prescriptions for clozapine and clozapine management.
- Copies of laboratory results of WBC (white blood cell) counts and ANC (absolute neutrophil count) testing.
- Signed and dated notes documenting all clozapine management services. Indicate date of all blood draws as well as who performed the blood draws. If the provider had to travel to provide services, indicate the travel time. Document services provided to ensure that the member received medically necessary care following an abnormal blood test results.

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

Topic #2610

Reimbursement Not Available

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

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

Topic #2614

Separately Reimbursable Services

Blood Testing

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

Member Transportation

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

Codes

Topic #6717

Administration Procedure Codes for Physician-Administered Drugs

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

Topic #9938

Age-Restricted Contraceptive HCPCS Procedure Codes

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

HCPCS (Healthcare Common Procedure Coding System) procedure codes and descriptions for age-restricted contraceptives are in the table below. Procedure codes for Medicaid-covered contraceptives are listed in the maximum allowable fee schedule.

Age-Restricted Contraceptives	
Procedure Code	**Description**
J7294	Segesterone acetate and ethinyl estradiol 0.15 mg, 0.013 mg per 24 hours; yearly vaginal system, each
J7295	Ethinyl estradiol and etonogestrel 0/015 mg, 0.12 mg per 24 hours; monthly vaginal ring, each
J7297	Levonorgestrel-releasing intrauterine contraceptive system (lilleta), 52 mg
J7298	Levonorgestrel-releasing intrauterine contraceptive system (mirena), 52 mg
J7300	Intrauterine copper contraceptive
J7301	Levonorgestrel-releasing intrauterine contraceptive system (skyla), 13.5 mg
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
S4993-U1	Contraceptive pills for birth control—emergency contraception

Topic #471

Bone-Anchored Hearing Devices

The following are allowable HCPCS (Healthcare Common Procedure Coding System) procedure codes for bone-anchored hearing devices or bone-anchored hearing device repairs or replacement parts. These procedure codes are separately reimbursable for members residing in a nursing home.

The DME (Durable Medical Equipment) and DMS (Disposable Medical Supply) indices list the maximum allowable fees for the following procedure codes, as applicable.

Bone-Anchored Hearing Devices	
Procedure Code	**Description**
L8690	Auditory osseointegrated device, includes all internal and external components
L8692	Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of attachment

Bone-Anchored Hearing Device Repairs or Replacement Parts	
Procedure Code	**Description**
L7510	Repair of prosthetic device, repair or replace minor parts
L8691	Auditory osseointegrated device, external sound processor, excludes transducer/actuator, replacement only, each
L8694	Auditory osseointegrated device transducer/actuator, replacement only, each
V5266	Battery for use in hearing device

Topic #17537

Cellular/Tissue-Based Products

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

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

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

Q4101	Apligraf, per square centimeter	**Venous leg ulcers**	**15271–15278**	I83.001–I83.029	Varicose veins of lower extremity with ulcer
				I83.201–I83.229	Varicose veins of lower extremity with ulcer and inflammation
				I87.2	Venous insufficiency (chronic) (peripheral)
				I70.231*–I70.25*	Atherosclerosis of native arteries of leg with ulceration
				I70.331*–I70.749*	Atherosclerosis of bypass graft(s) of leg with ulceration
				L97.201*–L97.529*	Non-pressure chronic ulcer
		Full-thickness neuropathic diabetic foot ulcers	**15275–15278**	E08.621, E09.621, E10.621, E11.621, E13.621	Diabetes mellitus with foot ulcer
				E08.622, E09.622, E10.622, E11.622, E13.622	Diabetes mellitus with other skin ulcer
				L97.301**–L97.529**	Non-pressure chronic ulcer of ankle, heel, or foot
Q4116	Alloderm, per square centimeter	**Breast reconstructive surgery**	**15271–15274, 15777**	C50.011–C50.019	Malignant neoplasm of nipple and areola, female
				C50.111–C50.119	Malignant neoplasm of central portion of breast, female
				C50.211–C50.219	Malignant neoplasm of upper-inner quadrant of breast, female
				C50.311–C50.319	Malignant neoplasm of lower-inner quadrant of breast, female

C50.411–C50.419	Malignant neoplasm of upper-outer quadrant of breast, female
C50.511–C50.519	Malignant neoplasm of lower-outer quadrant of breast, female
C50.611–C50.619	Malignant neoplasm of axillary tail of breast, female
C50.811–C50.819	Malignant neoplasm of overlapping sites of breast, female
C50.911–C50.919	Malignant neoplasm of breast of unspecified site, female
C50.021–C50.029	Malignant neoplasm of nipple and areola, male
C50.121–C50.129	Malignant neoplasm of central portion of breast, male
C50.221–C50.229	Malignant neoplasm of upper-inner quadrant of breast, male
C50.321–C50.329	Malignant neoplasm of lower-inner quadrant of breast, male
C50.421–C50.429	Malignant neoplasm of upper-outer quadrant of breast, male
C50.521–C50.529	Malignant neoplasm of lower-outer quadrant of breast, male
C50.621–C50.629	Malignant neoplasm of axillary tail of breast, male
C50.821–C50.829	Malignant neoplasm of overlapping sites of breast, male
C50.921–C50.929	Malignant neoplasm of breast of unspecified site,

					male
				D05.00–D05.02	Lobular carcinoma in situ of breast
				D05.10–D05.12	Intraductal carcinoma in situ of breast
				D05.80–D05.82	Other specified type of carcinoma in situ of breast
				D05.90–D05.92	Unspecified type of carcinoma in situ of breast
				Z85.3	Personal history of malignant neoplasm of breast
				Z90.10–Z90.13	Acquired absence of breast and nipple
Q4132	Grafix core and GrafixPL core, per square centimeter	**Venous leg ulcers**	**15271–15278**	I83.001–I83.029	Varicose veins of lower extremity with ulcer
				I83.201–I83.229	Varicose veins of lower extremity with ulcer and inflammation
				I87.2	Venous insufficiency (chronic) (peripheral)
				I70.231*–I70.25*	Atherosclerosis of native arteries of leg with ulceration
				I70.331*–I70.749*	Atherosclerosis of bypass graft(s) of leg with ulceration
				L97.201*–L97.529*	Non-pressure chronic ulcer
		Full-thickness neuropathic diabetic foot ulcers	**15275–15278**	E08.621, E09.621, E10.621, E11.621, E13.621	Diabetes mellitus with foot ulcer
				E08.622, E09.622, E10.622, E11.622,	Diabetes mellitus with other skin ulcer

				E13.622	
				L97.301**–L97.529**	Non-pressure chronic ulcer of ankle, heel, or foot
Q4133	Grafix prime and GrafixPL prime, per square centimeter	**Venous leg ulcers**	**15271–15278**	I83.001–I83.029	Varicose veins of lower extremity with ulcer
				I83.201–I83.229	Varicose veins of lower extremity with ulcer and inflammation
				I87.2	Venous insufficiency (chronic) (peripheral)
				I70.231*–I70.25*	Atherosclerosis of native arteries of leg with ulceration
				I70.331*–I70.749*	Atherosclerosis of bypass graft(s) of leg with ulceration
				L97.201*–L97.529*	Non-pressure chronic ulcer
		Full-thickness neuropathic diabetic foot ulcers	**15275–15278**	E08.621, E09.621, E10.621, E11.621, E13.621	Diabetes mellitus with foot ulcer
				E08.622, E09.622, E10.622, E11.622, E13.622	Diabetes mellitus with other skin ulcer
				L97.301**–L97.529**	Non-pressure chronic ulcer of ankle, heel, or foot
Q4186	Epifix, per square centimeter	**Venous leg ulcers**	**15271–15278**	I83.001–I83.029	Varicose veins of lower extremity with ulcer
				I83.201–I83.229	Varicose veins of lower extremity with ulcer and inflammation
				I87.2	Venous insufficiency (chronic) (peripheral)
				I70.231*–I70.25*	Atherosclerosis of native

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

				E13.621	
				E08.622, E09.622, E10.622, E11.622, E13.622	Diabetes mellitus with other skin ulcer
				L97.301** – L97.529**	Non-pressure chronic ulcer of ankle, heel, or foot

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

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

Topic #4012

Cochlear Implants

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

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

Cochlear Implant Devices	
Code	**Description**
L7510	Repair of prosthetic device, repair or replace minor parts
L8614	Cochlear device, includes all internal and external components
L8615	Headset/headpiece for use with cochlear implant device, replacement
L8616	Microphone for use with cochlear implant device, replacement
L8617	Transmitting coil for use with cochlear implant device or auditory osseointegrated device, replacement
L8618	Transmitter cable for use with cochlear implant device, replacement
L8619	Cochlear implant, external speech processor and controller, integrated system, replacement
L8621	Zinc air battery for use with cochlear implant device, replacement, each
L8622	Alkaline battery for use with cochlear implant device, any size, replacement, each
L8623	Lithium ion battery for use with cochlear implant device speech processor; other than ear level, replacement, each
L8624	Lithium ion battery for use with cochlear implant or auditory osseointegrated device speech processor, ear level, replacement, each
L8625	External recharging system for battery for use with cochlear implant or auditory osseointegrated device, replacement only, each
L8627	Cochlear implant, external speech processor, component, replacement

L8628	Cochlear implant, external controller component, replacement
L8629	Transmitting coil and cable, integrated for use with cochlear implant device, replacement

Replacement Parts for Cochlear Implants

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

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

Topic #4945

Physicians Required to Obtain Separate Enrollment

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

Topic #564

Modifiers

ForwardHealth accepts all valid, nationally recognized modifiers on claims and forms. Some modifiers impact claims processing and reimbursement while others are informational. Providers should refer to CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) guidelines for modifier definitions as well as information on appropriately using nationally recognized modifiers when submitting claims and other forms to ForwardHealth.

ForwardHealth also requires providers to indicate ForwardHealth-specific modifiers on claims and forms as appropriate. The modifiers in the following table have been specifically defined by ForwardHealth for physician, E&M (evaluation and management), and surgery services.

Modifier	Description	Notes
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 maximum allowable fee schedule identifies procedures for which this modifier is allowable.
AQ	Physician providing a service in an unlisted HPSA (Health Professional Shortage Area) (Note: While the AQ modifier is defined for	Providers receive enhanced reimbursement when services are performed in a HPSA.

	physicians only, any Medicaid HPSA-eligible provider may use the modifier when appropriate.)	
TH	Obstetrical treatment/services, prenatal or postpartum	If a provider renders three or fewer antepartum care visits, the provider is required to include modifier TH with the appropriate E&M service code (99202–99215, G2212, and/or 99341–99350) to indicate that the code is being used for obstetrical treatment/services. If the services are HPSA eligible, the provider should include the HPSA modifier AQ in addition to modifier TH.
TJ	Program group, child and/or adolescent	Providers are required to use modifier TJ with procedure codes 99202–99215, G2212, 99281–99285, and 99341–99350 for members 18 years of age and younger. Providers should not use the HPSA modifier AQ with modifier TJ. Providers should **only** include the HPSA modifier in situations where both of these modifiers apply.
U1	Nonelective Cesarean Section (locally defined for physicians)	Providers may use modifier U1 with procedure codes 59510, 59514, and 59515 to indicate nonelective cesarean sections.
U5	Intrathecal Infusion Pump-Trial (locally defined for physicians)	Providers are required to use modifier U5 with procedure codes 62320, 62321, 62322, and 62323 to indicate trial bolus doses of either baclofen or opioid pain killers.
UD	Clozapine Management (locally defined)	Providers may use modifier UD with procedure code H0034 only.

Topic #565

Place of Service Codes

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

POS Code	Description
01	Pharmacy
02	Telehealth Provided Other Than in Patient's Home
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
10	Telehealth Provided in Patient's Home
11	Office

12	Home
13	Assisted Living Facility
15	Mobile Unit
17	Retail Walk-In Clinic
19	Off Campus—Outpatient Hospital
20	Urgent Care Facility
21	Inpatient Hospital
22	On Campus—Outpatient Hospital
23	Emergency Room—Hospital
24	Ambulatory Surgical Center
25	Birthing Center
27	Outreach Site/Street
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	Intermediate Care Facility/Individuals With Intellectual Disabilities
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
71	Public Health Clinic
72	Rural Health Clinic

A complete list of expanded definitions for POS codes is available on the CMS (Centers for Medicare and Medicaid Services) website.

Topic #566

Procedure Codes

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

Topic #23638

Procedure Codes and Modifier for IV Ketamine Infusion Therapy Claims

Providers must use the most appropriate CPT (Current Procedural Terminology) code(s) with the U4 modifier on all claim details for IV ketamine infusion therapy for MDD (major depressive disorder) with or without suicidality. HCPCS (Healthcare Common Procedure Coding System) code J3490 (Unclassified drugs) also must be indicated on the claim.

The CPT codes for IV ketamine infusion therapy are:

- 96365 (Intravenous infusion, for therapy, prophylaxis, or diagnosis [specify substance or drug]; initial, up to 1 hour).
- 96366 (Intravenous infusion, for therapy, prophylaxis, or diagnosis [specify substance or drug]; each additional hour).
- 96374 (Therapeutic, prophylactic, or diagnostic injection [specify substance or drug]; intravenous push, single or initial substance/drug).
- 96375 (Therapeutic, prophylactic or diagnostic injection [specify substance or drug], each additional sequential intravenous push of a new substance/drug).

Providers must use code J3490 with the U4 modifier to indicate the drug component of the IV ketamine infusion therapy. Claims for J3490 without the U4 modifier will be denied. Providers must bill each unit of ketamine in milliliters (mL), with one HCPCS billing unit equal to 1 mL.

The table below outlines how units of time for IV ketamine infusion therapy are billed for CPT codes 96365, 96366, 96374, or 96375.

Billing Time for IV Ketamine Infusion Therapy	
CPT® Code(s) With J3490 and the U4 Modifier	**IV Push Medication Is Used**
When CPT code 96365 and HCPCS code J3490 with the U4 modifier are billed, the IV ketamine infusion can range from 16–90 minutes.	If an IV push medication is given to the member, then the provider will use CPT code 96374 without the U4 modifier for the first medication and CPT code 96375 without the U4 modifier for each additional IV push drug.
When CPT codes 96365 and 96366 and HCPCS code J3490 with the U4 modifier are billed, the IV ketamine infusion is greater than 91 minutes.	If an IV push medication is given to the member, then the provider will use CPT code 96374 without the U4 modifier for the first medication and CPT code 96375 without the U4 modifier for each additional IV push drug.
When CPT code 96374 and HCPCS code J3490 with the U4 modifier are billed, the IV ketamine infusion is less than 16 minutes.	If an IV push medication is given to the member, then the provider will use CPT code 96375 without the U4 modifier.

Providers may refer to the interactive maximum allowable fee schedules on the Portal for the reimbursement rates for CPT codes 96365, 96366, 96374, and HCPCS code J3490 with the U4 modifier for IV ketamine infusion therapy submitted on professional claims.

Topic #15297

Procedures Reimbursable Only as Inpatient Hospital Services

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

The CMS (Centers for Medicare & Medicaid Services) website includes a list of the services that are only reimbursable when provided in inpatient hospitals.

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

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

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

Topic #13817

Restorative Plastic Surgery and Procedures

ForwardHealth covers restorative plastic surgeries and procedures when medically necessary per Wis. Admin. Code § DHS 101.03(96m); however, PA (prior authorization) is required for coverage of certain surgeries and procedures.

Note: PA is not required for reconstruction after surgery for breast cancer.

The following table lists allowable CPT (Current Procedural Terminology) procedure codes for restorative plastic surgery and procedures that require PA.

Surgery	
CPT® Procedure Code(s)	**Service Description**
11200–11201	Removal of skin tags
11920–11922	Tattooing
11950–11954	Subcutaneous injection of filling material (eg, collagen)
15771–15774*	Grafting of autologous fat or soft tissue
15780–15782	Dermabrasion
15786–15793	Abrasion and chemical peels
15820–15823	Blepharoplasty
15824–15829	Rhytidectomy
17360	Chemical exfoliation for acne (eg, acne paste, acid)
19316*	Mastopexy
19325*	Mammaplasty, augmentation
19355	Correction of inverted nipples
19340–19365, 19367–19369*	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction

19370	Open periprosthetic, capsulotomy, breast
19371	Periprosthetic capsulectomy, breast
19380*	Revision of reconstructed breast
19396*	Preparation of moulage for custom breast implant
21083**	Impression and custom preparation; palatal lift prosthesis
21087**	Nasal prosthesis
21120–21123**	Genioplasty
21137	Reduction forehead; contouring only
21270**	Malar augmentation, prosthetic material
21280–21282	Medial or lateral canthopexy
30120	Excision or surgical planing of skin of nose for rhinophyma
30400–30450	Rhinoplasty
67900–67909	Repair of brow ptosis, repair of blepharoptosis
69300	Otoplasty, protruding ear, with or without size reduction

* Prior Authorization is not required for these procedures if they are performed following a mastectomy for breast cancer and if the claim includes an allowable breast cancer or personal history of breast cancer diagnosis code.

** Prior Authorization is required to process claims for DME (durable medical equipment) related to these procedures. The DME Index includes the PA requirements for DME.

Topic #17497

Services Rendered in Walk-In Retail or Convenient Care Clinics

Wisconsin Medicaid and BadgerCare Plus cover the following services, identified by CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) procedure codes, for members ages 6 years and older when rendered by Medicaid-enrolled nurse practitioners, pharmacists, physician assistants, and physicians in a walk-in retail or convenient care clinic.

Allowable Services	Allowable CPT® and HCPCS Procedure Codes
Low to mid-level E&M (evaluation and management) services	99202–99203, 99212–99213, G2212*
Influenza, pneumococcal, and certain tetanus vaccines	90656, 90658, 90660, 90661, 90670, 90672, 90673, 90686, 90688, 90714, 90715, 90732
Dipstick urinalysis	81000, 81002
Rapid strep throat test	87880
Pregnancy test	81025

*Procedure code G2212 is covered as an add-on procedure code to procedure code 99205.

Topic #18198

Sleep Medicine Testing

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

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

Allowable Facility-Based Sleep Studies and Polysomnography Procedure Codes

CPT (Current Procedural Terminology)® Procedure Code	Description
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (for example, by airflow or peripheral aterial tone), and sleep time
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, respiratory analysis (for example, by airflow or peripheral aterial tone)
95805 Multiple Sleep Latency Test/Maintenance of Wakefulness Test	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness
95806 Unattended Sleep Study—Type III	Sleep study, unattended, simultaneous recording of heart rate, oxygen saturation, respiratory airflow, and respiratory effort (for example, thoracoabdominal movement)
95807 In-Lab Sleep Study (PSG)	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist
95808 In-Lab Sleep Study (PSG)	Polysomnography; any age, sleep staging with 1–3 additional parameters of sleep, attended by a technologist
95810 In-Lab Sleep Study (PSG)	age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95811 In-Lab Sleep Study (PSG)	age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist
95782 In-Lab Sleep Study (PSG)	younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95783 In-Lab Sleep Study (PSG)	younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist

Allowable Home-Based Sleep Studies Procedure Codes

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

Topic #643

Unlisted Procedure Codes

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

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

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

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

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

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

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

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

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

- Include only relevant documentation.
- Include all required clinical/supporting documentation.

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

Unlisted Codes That Do Not Require Prior Authorization

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

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

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

How to Submit Claims and Related Documentation

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

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

Topic #13777

Vagus Nerve Stimulators

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

Vagus Nerve Stimulator Implant Surgery Procedure Codes	
Code	**Description**
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array

61886	with connection to 2 or more electrode arrays
61888	Revision or removal of cranial neurostimulator pulse generator or receiver
64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator
64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator

Topic #830

Valid Codes Required on Claims

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

Code Validity

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

Code Specificity for Diagnosis

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

Covered Services and Requirements

Topic #646

A Comprehensive Overview

Physician services covered by Wisconsin Medicaid include:

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

Examples of these types of services include:

- Conducting examinations
- Offering treatment
- Prescribing, ordering, procuring, dispensing, and administering medications, medical devices, services, and supplies
- Performing surgery
- Providing medical advice
- Serving as primary care and specialty care providers
- Delegating a care task to another clinically trained healthcare worker

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

Topic #24343

BadgerCare Plus Postpartum Program Coverage

Pregnant members enrolled in BadgerCare Plus keep their health care coverage for 12 months after the end of their pregnancy, per 2025 Wisconsin Act 102. These members are eligible for all covered services during this postpartum period as part of their care.

Eligibility

Most full-benefit BadgerCare Plus or Medicaid members enrolled on their last day of pregnancy are eligible for an estimated 365 days of postpartum BadgerCare Plus coverage (The window of coverage occurs for 365 days through the end of the month in which the 365th day falls. For example, if the end of a qualifying member's pregnancy occurred on April 14, 2026, their postpartum coverage period would be complete on April 30, 2027).

If someone is already enrolled in BadgerCare Plus or Medicaid but does not report a pregnancy until after it has ended, they may still qualify for postpartum coverage, but they must be enrolled in the month in which the pregnancy ended.

If someone applies for coverage after their pregnancy has ended, they are eligible for 12-months of postpartum coverage if they obtain retroactive coverage for the month in which the pregnancy ended.

Exceptions

Members will not qualify for the 12-month BadgerCare Plus postpartum coverage period if any of these statements are true:

- They were enrolled in the BadgerCare Prenatal Program.
- They were only enrolled in BadgerCare through presumptive eligibility, also known as Express Enrollment.
- Their pregnancy ended before January 1, 2026.

Circumstances when coverage may end

The 12-month postpartum coverage period can end prior to the 12 months only if the member:

- Gained eligibility based on incorrect information or agency error.
- Asks to be disenrolled from coverage.
- Moves outside of Wisconsin.
- Dies.

Topic #23077

Beyfortus Covered Through the Vaccines for Children Program

Beyfortus (nirsevimab), a monoclonal antibody, is used for the prevention of lower respiratory tract disease caused by RSV (respiratory syncytial virus) in infants or children.

The CDC (Centers for Disease Control and Prevention)'s ACIP (Advisory Committee on Immunization Practices) recommends the routine use of Beyfortus for the prevention of RSV for newborns and infants younger than 8 months of age born during or entering their first RSV season. The ACIP also recommends the routine use of Beyfortus for children aged 8 to 19 months who are at increased risk of severe RSV, which includes Alaska Native and American Indian children, as defined by the Indian Health Care Improvement Act, who are entering their second RSV season.

Beyfortus Supplied Through the Vaccines for Children Program

The federal VFC (Vaccines for Children) Program was created to provide vaccines to eligible children through enrolled public and private providers. The VFC Program is part of a national approach to improving immunization services and levels.

Although not a vaccine, the ACIP voted to include Beyfortus in the VFC Program.

ForwardHealth covers Beyfortus consistent with current policies for immunization services. Therefore, providers are required to obtain Beyfortus for children from the VFC supply. ForwardHealth reimburses only an administration code for Beyfortus supplied through the VFC Program.

Providers may refer to the Wisconsin Immunization Program for contact information about enrolling in the VFC Program.

Topic #13717

Bone-Anchored Hearing Devices

ForwardHealth covers unilateral bone-anchored hearing device implant surgeries, bilateral bone-anchored hearing device implant

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

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

Coverage Criteria for Unilateral Bone-Anchored Hearing Device Implant Surgeries

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

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

Coverage Criteria for Bilateral Bone-Anchored Hearing Device Implant Surgeries

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

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

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

Note: Profound unilateral sensorineural hearing loss with normal hearing in the opposite ear is sometimes referred to as unilateral sensorineural deafness or SSD (single-sided deafness).

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

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

Non-Implant Bone-Anchored Hearing Devices

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

Topic #15757

Botulinum Toxins

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

- OnabotulinumtoxinA
- Rimabotulinumtoxin
- AbobotulinumtoxinA
- IncobotulinumtoxinA

Each preparation has distinct pharmacological and clinical profiles.

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

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

Topic #17517

Cellular/Tissue-Based Products

ForwardHealth covers CTPs (cellular/tissue-based products) in limited circumstances where evidence of efficacy is strong. ForwardHealth only covers CTPs for wound treatment for members with neuropathic diabetic foot ulcers, non-infected venous leg ulcers, or members who are undergoing breast reconstruction surgery following a breast cancer diagnosis.

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

Product Coverage Review Policy

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

Topic #771

Certificate of Need for Transportation

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

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

If a member meets the criteria, a physician, physician assistant, nurse practitioner, or nurse midwife should complete a Certification of Need for Specialized Medical Vehicle Transportation (F-01197 (06/2009)) form.

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

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

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

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

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

Topic #573

Cochlear Implant Surgeries

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

Coverage Criteria

General Coverage Criteria

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

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

Coverage Criteria for Children

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

- The family has been properly informed about all aspects of the cochlear implant, including evaluation, surgical, and rehabilitation procedures.
- The member is scheduled to attend a concentrated oral and/or aural rehabilitation program recommended by the cochlear implant team through the Birth to 3 Program, local school, rehabilitation site, etc.
- For children under 12 months of age, a cochlear implant team has documented the medical necessity of implantation, and implantation is not medically contraindicated by current evidence-based research or anatomy development.
- For children 12 to 24 months of age, a cochlear implant team has documented the following:
    - Unilateral or bilateral severe to profound pre- or post-lingual sensorineural hearing loss, defined as a hearing threshold of pure-tone average of 70 dB (decibels) hearing loss or greater at 500 Hz (hertz), 1000 Hz, and 2000 Hz.
    - A lack of progress in the development of auditory skills in conjunction with appropriate binaural amplification and participation in intensive auditory rehabilitation over a three-to-six-month period. Limited benefit from amplification may be quantified by measures including, but not limited to, the Meaningful Auditory Integration Scale or the Early Speech Perception Test.
- For children 24 months of age and older, a cochlear implant team has documented the following:
    - Unilateral or bilateral severe to profound pre- or post-lingual sensorineural hearing loss, defined as a hearing threshold of pure-tone average of 70 dB hearing loss or greater at 500 Hz, 1000 Hz, and 2000 Hz.
    - A lack of progress in the development of auditory skills in conjunction with appropriate binaural amplification and participation in intensive auditory rehabilitation over a three-to-six-month period. Limited benefit from amplification is defined and may be quantified as demonstrated by the following:
        - An aided score of 30% or less on the MLNT (Multisyllabic Lexical Neighborhood Test) for children 24 months of age.
        - An aided score of 30% or less on the LNT (Lexical Neighborhood Test) for children 25 months to 5 years of age.
        - A test that may vary depending upon the child's cognitive and linguistic skills for children 5 years of age and older.

Coverage Criteria for Adults

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

- The member has a moderate to profound bilateral sensorineural hearing loss (50 dB or poorer averaged over 500-2000 Hz

in the better ear).
- The member demonstrates limited benefit from amplification as defined by test scores of less than 50% correct in the best aided listening condition on recorded open-set sentence tests.

Documentation Requirements

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

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

Facilities Must Be Medicaid-Enrolled Durable Medical Equipment Providers

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

Topic #17897

Continuous Glucose Monitoring

Professional Continuous Glucose Monitoring (Provider-Owned Equipment)

Professional continuous glucose monitoring utilizing provider-owned equipment is covered for BadgerCare Plus and Medicaid members as a supplement to standard care for diabetes when the primary care provider or attending provider determines such monitoring is medically necessary to establish an optimal insulin regimen. Results must be monitored and interpreted under the supervision of a qualified health care professional.

Professional continuous glucose monitoring is a diagnostic measurement of glucose levels received throughout the day and night. This type of glucose monitoring is done as a three-five day test to evaluate diabetes control.

The following CPT (Current Procedural Terminology) procedure codes are covered for members receiving professional continuous glucose monitoring:

- 95250 (Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional [office] provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording).
- 95251 (Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report).

Procedure codes 95250 and 95251 require a minimum of 72 hours of data and may be reimbursed up to four times per year but may not be reimbursed more than once per month. PA (prior authorization) is not required.

Supplies and equipment are not separately reimbursable as they are included in the reimbursement for procedure code 95250.

Allowable provider types and POS (places of service) are listed on the interactive maximum allowable fee schedule.

Note: Procedure code 99091 (Collection and interpretation of physiologic data [eg, ECG, blood pressure, glucose monitoring] digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation [when applicable] requiring a minimum of 30 minutes of time, each 30 days) should not be used with professional continuous glucose monitoring and cannot be reported in conjunction with procedure code 95250 or 95251. Procedure code 95251 does not require a face-to-face visit.

Documentation Requirements

The member's medical record must include documentation supporting the medical necessity of professional continuous glucose monitoring to establish an optimal insulin regimen for a member with insulin-requiring diabetes and documented inadequate glycemic control. The documentation must also include monitor calibration, member training, sensor removal, and recording printout, as well as the qualified health care professional's report with interpretation and findings based on information obtained during monitoring.

Personal Continuous Glucose Monitoring (Purchased for Individual Member)

ForwardHealth covers personal continuous glucose monitors and supplies for members who are diagnosed with any type of diabetes, excluding pre-diabetes, when ForwardHealth requirements are met. Continuous glucose monitors and supplies are covered under ForwardHealth's DME (durable medical equipment) benefit.

Providers may prescribe age-appropriate personal glucose monitors and supplies for both adult and child members (including infants and toddlers) who are diagnosed with any type of diabetes, excluding pre-diabetes.

Coverage Requirements

Providers may prescribe continuous glucose monitors and supplies for members with diabetes who meet all these criteria:

- The member is under the care of a qualified health care professional who is managing the member's diabetes.
- The member has a diagnosis of any type of diabetes, excluding pre-diabetes.
- The member or the member's caregiver has the cognitive ability to be educated about the device, the willingness to use the device, and the physical capability to use the device.
- The prescription is written by a qualified health care professional who is managing the member's diabetes, is dated within the last 12 months, and includes the name of the prescribed continuous glucose monitor.
- The member has a diabetic treatment plan ordered by a qualified health care professional who is managing the member's diabetes.
- The prescribed continuous glucose monitor is appropriate for the member's age.

These criteria must be documented in the member's medical record and provided to the Wisconsin DHS (Department of Health Services) upon request.

Note: There are situations where PA is required for coverage of continuous glucose monitors. In addition, HMOs can still require PA for continuous glucose monitors.

Allowable Procedure Codes

The following HCPCS (Healthcare Common Procedure Coding System) procedure codes are allowable for personal continuous glucose monitoring devices and supplies:

- A4239 (Supply allowance for non-adjunctive, non-implanted continuous glucose monitor [cgm], includes all supplies and accessories, 1 month supply = 1 unit of service)
- A9276 (Sensor; invasive [e.g., subcutaneous], disposable, for use with interstitial continuous glucose monitoring system, one unit = 1 day supply)
- A9277 (Transmitter; external, for use with interstitial continuous glucose monitoring system)
- A9278 (Receiver [monitor]; external, for use with interstitial continuous glucose monitoring system)
- E2103 (Non-adjunctive, non-implanted continuous glucose monitor or receiver)

Note: Providers should use the KX modifier when billing for members who are insulin treated, and providers should use the KS modifier when billing for members who are non-insulin treated. In cases where PA is required, DME vendors should indicate procedure codes E2103 or A9278. For more information, refer to the DMS (disposable medical supplies) Index.

Topic #9937

Contraceptives

Age restrictions and quantity limits for certain contraceptives apply to members enrolled in BadgerCare Plus, Wisconsin Medicaid, and Family Planning Only Services.

Age Restrictions

Age restrictions apply to certain contraceptives.

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

Quantity Limits

Quantity limits apply to certain contraceptives.

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

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

Duplicate Claims

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

If a claim is denied as a duplicate, and the member meets one of the following criteria, pharmacy providers should resubmit the claim and a completed Written Correspondence Inquiry (F-01170 (07/2012)) form with an explanation to ForwardHealth. Examples of when duplicate claims will be reimbursed by Wisconsin Medicaid include:

- If the member has an appropriate medical need (for example, the member's medications were lost or stolen, the member has requested a vacation supply).
- If the member experienced a medical problem while taking one contraceptive and was switched to another contraceptive.
- If the prescriber changed the directions for administration of the drug and did not inform the pharmacy provider.

Topic #44

Definition of Covered Services

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

Topic #85

Emergencies

Certain program requirements and reimbursement procedures are modified in emergency situations. Emergency services are defined in Wis. Admin. Code § DHS 101.03(52), as those services that are necessary to prevent the death or serious impairment of the health of the individual. Emergency services are not reimbursed unless they are covered services.

Additional definitions and procedures for emergencies exist in other situations, such as dental and mental health.

Program requirements and reimbursement procedures may be modified in the following ways:

- PA (prior authorization) or other program requirements may be waived in emergency situations.
- Non-U.S. citizens may be eligible for covered services in emergency situations.

Topic #16957

Emerging Molecular Pathology and Diagnostic Genetic Testing

Coverage Policy

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

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

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

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

Clinically Useful Criteria

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

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

Documentation

All providers who receive payment from Wisconsin Medicaid, including state-contracted managed care organizations, are required to maintain records that fully document the basis of charges upon which all claims for payment are made, according to Wis. Admin. Code § DHS 106.02(9)(a). Records should clearly support the services rendered and the procedure codes being submitted on claims.

PA

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

Genetic Counseling Requirement

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

Providers who provide genetic counseling should supply the following:

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

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

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

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

Documentation Requirements for Genetic Testing Services Not Requiring PA

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

Familial Variants

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

Fetal Aneuploidy Testing Using Cell-Free Fetal Deoxyribonucleic Acid

Wisconsin Medicaid and BadgerCare Plus cover fetal aneuploidy testing using cell-free fetal DNA in maternal blood tests without PA in cases that meet the guidelines published by the ACOG (American Congress of Obstetricians and Gynecologists). DNA (deoxyribonucleic acid)-based noninvasive prenatal tests of fetal aneuploidy are proven and medically necessary as screening tools for trisomy 21 (Down syndrome), trisomy 18 (Edwards syndrome), and trisomy 13 (Patau syndrome).

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

Other Tests Allowed Based on ACMG Guidelines

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

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

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

Panel Versus Component Coding

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

Reporting Tier 2 and Unlisted Molecular Pathology Codes

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

Topic #18597

Hyperbaric Oxygen Therapy

HBOT (hyperbaric oxygen therapy) is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure. ForwardHealth requires PA (prior authorization) for HBOT provided in an office or outpatient hospital. ForwardHealth does not require PA for HBOT provided in an inpatient hospital setting.

ForwardHealth covers HBOT when administered in a chamber (including the one-man unit).

Requirements

Physicians, physician assistants, and nurse practitioners supervising HBOT are required to meet one of the following educational certification requirements:

- Have certification in Undersea and Hyperbaric Medicine (certification provided by the ABEM (American Board of Emergency Medicine))
- Be certified by the ABPM (American Board of Preventive Medicine)
- Be certified by the AOCUHM (American Osteopathic Conjoint Committee of Undersea and Hyperbaric Medicine)
- Have successfully completed a minimum 40-hour in-person accredited training program such as one approved by the American College of Hyperbaric Medicine or the Undersea and Hyperbaric Medical Society and have supervised at least 300 HBOTs

The physician, physician assistant, or nurse practitioner is required to be present in the location of the HBOT, with a maximum response time of five minutes allowed to get to the chamber in case of emergency or if assistance is needed. When HBOT is performed in a physician's office, the physician, physician assistant, or nurse practitioner is required to be present in the office.

A physician assistant or nurse practitioner may supervise HBOT services when all of the following criteria are met:

- The service is included within the physician assistant's or nurse practitioner's scope of practice.
- Their required supervision or collaborative agreement is with a physician qualified to provide HBOT services.
- They meet the educational certification requirements identified above.

Claim Submission Procedure Codes

For HBOT provided in an inpatient hospital setting, providers should submit an institutional claim and follow appropriate revenue code and procedure code billing per NUBC (National Uniform Billing Committee) billing instructions.

For HBOT provided in an outpatient hospital or office setting, providers may submit the following procedure codes:

- G0277 (Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval), outpatient hospital code effective for DOS (dates of service) on and after January 1, 2015. ForwardHealth allows procedure code G0277 for HBOT services performed in an office setting effective for DOS on and after September 1, 2015.
- 99183 (Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session).

To receive Medicaid reimbursement for HBOT, providers are required to use the most appropriate CPT (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) procedure code that describes the procedure or service being performed or provided; they are also required to meet all CPT and HCPCS coding and billing requirements.

Topic #503

Immunizations and Vaccines

Providers are required to indicate:

- Both the vaccine product and vaccine administration CPT (Current Procedural Terminology) codes on all claims.
- Their usual and customary charge for the service with the procedure code.

When vaccine product obtained through the VFC (Vaccines for Children) Program is administered to members 18 years of age or younger, providers must also include the SL modifier (State-supplied vaccine).

The most current list of allowable procedure codes for vaccines administered is in the service-specific interactive maximum allowable fee schedule.

Reimbursement for "Immune Globulins" and "Vaccines, Toxoids"

ForwardHealth covers the immunizations identified by CPT subsections "Immune Globulins" (procedure codes 90281–90399) and "Vaccines, Toxoids" (procedure codes 90476–90749).

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 this information to a paper claim:

- Name of drug
- NDC (National Drug Code)
- Dosage
- Quantity (for example, vials, milliliters, milligrams)

Medicaid reimbursement for immune globulins 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 Members 18 Years of Age or Younger

Most vaccines provided to members 18 years of age or younger are available through the federal VFC (Vaccines for Children) Program at no cost to the provider.

- If a vaccine is available through the VFC Program, providers are required to use vaccines from VFC supply for members 18 years of age or younger.
- ForwardHealth reimburses only the administration fee for vaccines supplied by the VFC Program.

For vaccines that are not supplied by the VFC Program, providers may use a vaccine from a private stock. In these cases, ForwardHealth reimburses for the vaccine and the administration fee.

The Wisconsin Immunization Program has more information about the VFC Program. Providers may also call the VFC Program at 608-267-9959 or email VFC@dhs.wisconsin.gov.

Vaccines that are commonly combined, such as MMR (measles, mumps, and rubella) or DTaP (diphtheria, tetanus, and acellular pertussis), are not separately reimbursable unless the medical necessity for separate administration of the vaccine is documented in the member's medical record.

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.

Topic #22917

Interpretive Services

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

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

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

Covered Interpretive Services

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

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

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

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

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

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

ForwardHealth requirements for services provided via telehealth by out-of-state providers are the same as the ForwardHealth policy for services provided in-person by out-of-state providers. Requirements for out-of-state providers for interpretive services are the same whether the service is provided via telehealth or in-person. Out-of-state providers who are not enrolled as either

border-status or telehealth-only border-status providers are required to obtain PA before providing services via telehealth to BadgerCare Plus or Medicaid members. The PA would indicate that interpretive services are needed.

Documentation

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

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

Third-Party Vendors and In-House Interpreters

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

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

Limitations

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

Claims Submission

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

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

Noncovered Services

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

- Interpretive services provided in conjunction with a noncovered, non-reimbursable, or excluded service
- Interpretive services provided by the member's family member, such as a parent, spouse, sibling, or child
- The interpreter's waiting time and transportation costs, including travel time and mileage reimbursement, for interpreters to get to or from appointments
- The technology and equipment needed to conduct interpretive services
- Interpretive services provided directly by the HMOs and MCOs are not billable to ForwardHealth for reimbursement via procedure code T1013

Cancellations or No Shows

Providers cannot submit a claim for interpretive services if an appointment is cancelled, the member or the interpreter is a no-show

(is not present), or the interpreter is unable to perform the interpretation needed to complete the appointment successfully.

Procedure Code and Modifiers

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

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

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

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

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

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

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

Delivery Method of Interpretive Services	Definition for Sign Language and Foreign Language Interpreters		Modifiers
In person (foreign language and sign language)	When the interpreter is physically present with the member and provider		U1 or U3
Telehealth* (foreign language and sign language)	When the member is located at an originating site and the interpreter is available remotely (via audio-visual or audio only) at a distant site		U1 or U3 **and** GT or 93
	Phone (foreign language only)	When the interpreter is not physically present with the member and the provider and interprets via audio-only through the phone	U1 **and** 93
	Interactive video (foreign	When the interpreter is not physically present with the member and the provider and interprets on interactive video	U1 or U3 **and** GT

	language and sign language)		

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

Dental Providers

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

Allowable Places of Service

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

Federally Qualified Health Centers

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

Rural Health Clinics

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

Interpreter Qualifications

The two types of allowable interpreters include:

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

Qualifications for Sign Language Interpreters

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

Qualifications for Foreign Language Interpreters

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

interpreters.

A competent foreign language interpreter should:

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

Topic #17937

Low-Dose Computed Tomography Scans

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

ForwardHealth requires PA for coverage of all other CT scans, including those that would be performed as a follow up to the initial low-dose CT screening.

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

Note: This screening guidance is subject to change.

USPSTF guidance currently includes:

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

Topic #84

Medical Necessity

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

Topic #19797

Evaluation and Management Services

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

Topic #86

Member Payment for Covered Services

Under state and federal laws, a Medicaid-enrolled provider may not collect payment from a member, or authorized person acting on behalf of the member, for covered services even if the services are covered but do not meet program requirements. Denial of a claim by ForwardHealth does not necessarily render a member liable. However, a covered service for which PA (prior authorization) was denied is treated as a noncovered service. (If a member chooses to receive an originally requested service instead of the service approved on a modified PA request, it is also treated as a noncovered service.) If a member requests a covered service for which PA was denied (or modified), the provider may collect payment from the member if certain conditions are met.

If a provider collects payment from a member, or an authorized person acting on behalf of the member, for a covered service, the provider may be subject to program sanctions including termination of Medicaid enrollment.

Topic #5677

Not Otherwise Classified Procedure Codes

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

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

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

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

Topic #11097

Opioid Monthly Prescription Fill Limit

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

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

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

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

Prescriber Responsibilities

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

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

- The prescriber's name and NPI (National Provider Identifier)
- The member's name and ID
- The pharmacy's name and phone number where the member attempted to have the prescription filled
- The member's recent medication history
- The member's current opioid prescription information and if a policy override is medically necessary

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

Pharmacy Responsibilities

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

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

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

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

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

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

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

Schedule III and IV Drugs

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

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

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

- The pharmacy attempted to contact the prescriber (or the prescriber's designee), but the prescriber is unavailable (for example, the clinic is closed).
- The pharmacy staff must document on the prescription order that the prescriber is not available.
- The pharmacist determined that dispensing a 96-hour supply is medically necessary.
- An exception was not previously granted within the current calendar month; however, if the pharmacy was not aware of a previous exception within the current calendar month and dispensed the medication in good faith while the DAPO Center was closed, an override may be approved.

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

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

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

Schedule II Drugs

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

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

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

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

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

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

order.

Topic #23237

Over-the-Counter Contraception Standing Orders

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

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

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

Over-the-Counter Emergency Contraception—Levonorgestrel

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

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

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

Information for Medicaid Pharmacy Providers

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

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

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

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

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

Levonorgestrel

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

Pharmacies may dispense up to four tablets per prescription dispensed under the emergency contraception standing order. OTC levonorgestrel products have a quantity limit of eight tablets per member per month applied. Pharmacies may request an override of the monthly quantity limit by contacting the DAPO (Drug Authorization and Policy Override) Center.

Opill (Norgestrel)

Pharmacy providers may apply the standing order issued by the DMS chief medical officer to fill a prescription for Opill (norgestrel). This standing order fulfills the requirement of a prescription for BadgerCare Plus and Medicaid members to obtain covered FDA-authorized OTC oral contraception. It further authorizes providers to dispense such OTC products to BadgerCare Plus and Medicaid members to the extent a prescription is required, including for insurance coverage, under the pharmacy benefit.

Pharmacies may dispense up to 84 tablets for a three-month supply per prescription with PRN (pro re nata) or "as needed" refills, which will allow for up to a one-year supply to be authorized per use of the OTC oral contraception standing order.

Requirements for a Valid Prescription

Any prescription for members, including those based on standing orders, must be documented according to Wis. Admin Code § DHS 107.02(2m)(b). For documentation purposes, "the prescriber's MA provider number" in Wis. Admin. Code § DHS 107.02 (2m)(b) refers to that of the provider who authored the standing order. Providers must follow licensure scope of practice requirements when delegating dispensing or treatment authority per standing order.

Topic #23341

Pharmacists

Medicaid-enrolled pharmacists may render and/or bill for covered medical services that are not the typical pharmacy services included under the covered outpatient drug pharmacy benefit (for example, drug dispensing or drug consultation typically covered by a professional dispensing fee).

Examples of covered services include:

- Non-vaccine drug administration
- Chronic disease state management
- Member education and training
- Physician-delegated services via a CPA (collaborative practice agreement)

Topic #5697

Physician-Administered Drugs

A physician-administered drug is either an oral, injectable, intravenous, or inhaled drug administered by a physician or a medical professional within their scope of practice.

Providers may refer to the maximum allowable fee schedules for the most current HCPCS (Healthcare Common Procedure Coding System) and CPT (Current Procedural Terminology) procedure codes for physician-administered drugs and reimbursement rates.

Physician-administered drugs carve-out policy is defined to include the following procedure codes:

- Drug-related "J" codes

- Drug-related "Q" codes
- Certain drug-related "S" codes

The Physician-Administered Drugs Carve-Out Procedure Codes table indicates the status of procedure codes considered under the physician-administered drugs carve-out policy. This table provides information on Medicaid and BadgerCare Plus coverage status as well as carve-out status based on POS (place of service).

Note: The table will be revised in accordance with national annual and quarterly HCPCS code updates.

For members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, claims for these services should be submitted to BadgerCare Plus and Medicaid fee-for-service.

All fee-for-service policies and procedures related to physician-administered drugs, including copay, cost sharing, diagnosis restriction, PA (prior authorization), and pricing policies, apply to claims submitted to fee-for-service for members enrolled in an MCO (managed care organization).

Physician-administered drugs and related services for members enrolled in PACE (Program of All-Inclusive Care for the Elderly) are provided and reimbursed by the special managed care program.

Note: For Family Care Partnership members who are not enrolled in Medicare (Medicaid-only members), outpatient drugs (excluding diabetic supplies), physician-administered drugs, compound drugs (including parenteral nutrition), and any other drugs requiring drug utilization review are covered by fee-for-service Medicaid. All fee-for-service policies, procedures, and requirements apply for pharmacy services provided to Medicaid-only Family Care Partnership members. Dual eligibles (enrolled in Medicare and Medicaid) receive their outpatient drugs through their Medicare Part D plans. However, if the member's Part D plan does not cover the outpatient drug, these dually eligible members may access certain Medicaid outpatient drugs that are excluded or otherwise restricted from Medicare coverage through fee-for-service Medicaid. For these drugs, fee-for-service policies would apply.

Obtaining Physician-Administered Drugs

To ensure the content and integrity of the drugs administered to members, prescribers are required to obtain all drugs that will be administered in their offices. Prescribers may obtain a physician-administered drug from a pharmacy provider if the drug is delivered directly from the pharmacy to the prescriber's office. Prescribers may also obtain a drug to be administered in the prescriber's office from a drug wholesaler or direct purchase. Pharmacy providers should not dispense a drug to a member if the drug will be administered in the prescriber's office.

Topic #66

Program Requirements

For a covered service to meet program requirements, the service must be provided by a qualified Medicaid-enrolled provider to an enrolled member. In addition, the service must meet all applicable program requirements, including—but not limited to—medical necessity, PA (prior authorization), claims submission, prescription, and documentation requirements.

Topic #17457

Services Rendered in Walk-In Retail or Convenient Care Clinics

As defined by the Federal CMS (Centers for Medicare and Medicaid Services), walk-in retail and convenient care clinics are

clinic locations other than doctor offices, urgent care facilities, pharmacies, or independent clinics, located within a retail operation. Care in these clinics is usually provided by nurse practitioners, and services are limited to the following:

- Treatment of minor acute conditions
- Limited preventive services
- Vaccinations

Covered Services

Wisconsin Medicaid and BadgerCare Plus covers the following services for members aged 6 years and older when rendered by Medicaid-enrolled nurse practitioners, pharmacists, physician assistants, and physicians in a walk-in retail or convenient care clinic:

- Low to mid-level E&M (evaluation and management) services
- Influenza, and pneumococcal, and certain tetanus vaccines
- Dipstick urinalysis
- Rapid strep throat test
- Pregnancy test

Note: Higher level E&M services are not covered when provided in a walk-in retail or convenient care clinic as those codes indicate more complex levels of care. If, during the course of a clinic visit, a provider determines that additional care and services are required to manage a member's condition beyond the level of care indicated by the Wisconsin Medicaid and BadgerCare Plus-allowable E&M codes, the provider is required to make a referral to a care provider in an appropriate, non-retail setting where more intensive care may be provided. In this situation, Wisconsin Medicaid will reimburse the provider for allowable services provided at the walk-in retail or convenient care clinic.

Topic #824

Services That Do Not Meet Program Requirements

As stated in Wis. Admin. Code § DHS 107.02(2), BadgerCare Plus and Wisconsin Medicaid may deny or recoup payment for covered services that fail to meet program requirements.

Examples of covered services that do not meet program requirements include the following:

- Services for which records or other documentation were not prepared or maintained
- Services for which the provider fails to meet any or all of the requirements of Wis. Admin. Code § DHS 106.03, including, but not limited to, the requirements regarding timely submission of claims
- Services that fail to comply with requirements or state and federal statutes, rules, and regulations
- Services that Wisconsin DHS (Department of Health Services), the PRO (Peer Review Organization) review process, or BadgerCare Plus determines to be inappropriate, in excess of accepted standards of reasonableness or less costly alternative services, or of excessive frequency or duration
- Services provided by a provider who fails or refuses to meet and maintain any of the enrollment requirements under Wis. Admin. Code ch. DHS 105
- Services provided by a provider who fails or refuses to provide access to records
- Services provided inconsistent with an intermediate sanction or sanctions imposed by DHS

Topic #18177

Sleep Medicine Testing

Sleep medicine testing involves six or more hours of continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep with physician review, interpretation, and reporting. Polysomnography is distinguished from facility-based sleep studies and home-based sleep studies by the inclusion of sleep staging. Type IV sleep testing devices are not covered by ForwardHealth.

Coverage Requirements

Facility-Based Sleep Studies and Polysomnography

ForwardHealth covers facility-based sleep studies and polysomnography when ordered by the member's physician and performed in a sleep laboratory, an outpatient hospital, or an independent diagnostic testing facility for sleep disorders. Physicians interpretreting facility-based sleep studies and polysomnograms are required to have board certification in sleep medicine in order for the services to be reimbursed.

A list of allowable facility-based sleep study and polysomnography CPT (Current Procedural Terminology) procedure codes is available. Facility-based sleep study and polysomnography procedures do not require PA (prior authorization).

Home-Based Sleep Studies

ForwardHealth covers unattended home-based sleep studies when ordered by the member's physician. Physicians interpreting home-based sleep studies are required to have board certification in sleep medicine in order for the services to be reimbursed.

A list of allowable home-based sleep study HCPCS (Healthcare Common Procedure Coding System) procedure codes is available. Home-based sleep studies do not require PA.

Coverage Limitations for Sleep Medicine Testing

ForwardHealth does not cover:

- Unattended sleep studies for the diagnosis of obstructive sleep apnea in members with significant comorbid medical conditions that may affect the accuracy of the unattended sleep study, including, but not limited to, other sleep disorders
- Attendance of a nurse, home health aid, or personal care worker during a home-based sleep study
- Any parts of a home-based sleep study peformed by a DME (durable medical equipment) provider including, but not limited to, the delivery and/or pick up of the device
- Home-based sleep studies for children (ages 18 and younger)
- Abbreviated daytime sleep study (PAP-NAP) or daytime nap polysomnography

Topic #17959

Testing for Drugs of Abuse

Covered Services

Providers are required to use HCPCS (Healthcare Common Procedure Coding System) Level I and Level II procedure codes 80305–80307, G0480–G0483, and code G0659 when submitting claims for testing for drugs of abuse. Codes 80305–80307, G0480–G0483, and G0659 consist of two primary categories of drug testing: presumptive and definitive.

Presumptive drug tests are used to detect the presence or absence of a drug or drug class; they do not typically indicate a specific level of drug but rather give a positive or negative result. A presumptive drug test may be followed with a definitive drug test in order to identify specific drugs or metabolites.

Definitive drug tests are qualitative or quantitative tests used to identify specific drugs, specific drug concentrations, and associated metabolites.

Presumptive Drug Tests

ForwardHealth covers medically necessary presumptive drug tests for these clinical indications:

- Suspected drug overdose, unreliable medical history, and an acute medically necessary situation. Medically necessary situations can include: unexplained coma, unexplained altered mental status, severe or unexplained cardiovascular instability, undefined toxic syndrome, and seizures with an undetermined history.
- Monitoring of a member's compliance during treatment for substance abuse or dependence. This applies to testing during an initial assessment, as well as ongoing monitoring of drug and alcohol compliance. Decisions about which substances to screen for should be well documented and should be based on:
  - The member's history of past drug use or abuse, the results of any physical examinations, and any of the member's previous laboratory findings.
  - The substance the member is suspected of misusing.
  - The member's prescribed medication(s).
  - Substances that may present high risk for additive or synergistic interactions with the member's prescribed medication(s).
  - Local information about substances commonly abused and misused, such as input from the Substance Abuse and Mental Health Services Administration's Drug Abuse Warning Network that compiles prevalence data on drug-related emergency department visits and deaths.
- Monitoring of a member receiving COT (chronic opioid therapy). Decisions about which substances to screen for should be well documented and should be based on:
  - The member's history of past drug use or abuse, the results of any physical examinations, and any of the member's previous laboratory findings.
  - The member's current treatment plan.
  - The member's prescribed medication(s).
  - The member's risk assessment plan.

Definitive Drug Tests

Definitive drug tests can be used to evaluate presumptive drug test results, which can minimize the potential for a clinician to rely on a false negative or false positive result. Definitive drug tests can also be used to guide treatment when it is necessary to identify a specific drug within a drug class or identify a specific concentration of a drug. A definitive drug test order must be medically necessary and reasonable. The order for a definitive drug test must describe the medical necessity for each drug class being tested. A member's self-report may reduce the need for a definitive drug test.

Definitive drug testing includes direct-to-definitive drug tests, which are used without first performing a presumptive drug test on the sample. Direct-to-definitive drug tests are used when presumptive drug tests do not adequately detect the substance or metabolite identified for testing. Presumptive drug tests are inadequate when the component for a particular drug class does not react sufficiently to the identified drug or drug metabolite within that drug class, resulting in a false negative. Synthetic opioids, some benzodiazepines, or other synthetic drugs may not be adequately detected by presumptive drug tests. Direct-to-definitive drug tests are only appropriate in rare circumstances.

ForwardHealth covers medically necessary definitive drug tests for members when at least one of the clinical indications for presumptive drug tests applies and when there is at least one of these needs:

- A definitive concentration of a drug must be identified to guide treatment.
- A specific drug in a large family of drugs (for example, benzodiazepines, barbiturates, and opiates) must be identified to guide treatment.
- A false result must be ruled out for a presumptive drug test that is inconsistent with a member's self-report, presentation,

medical history, or current prescriptions.
- A specific substance or metabolite that is inadequately detected by presumptive drug testing (direct-to-definitive testing), as determined on a case-by-case basis in accordance with community standard guidelines set by the practice, must be identified.

Testing Frequency

Testing for drugs of abuse should not be performed more frequently than the standard of care for a particular clinical indication. The testing frequency must be medically necessary and documented in the member's medical record.

Acute Medical Testing

A single presumptive and/or definitive drug test is appropriate for any acute medical presentation.

Chronic Opioid Therapy

Providers are required to document the testing frequency and rationale for testing (including a validated risk assessment) for members receiving COT. These testing frequencies are based on a member's risk for abuse:

- Members with low risk for abuse may be tested up to one to two times per year.
- Members with moderate risk for abuse may be tested up to one to two times every six months.
- Members with high risk for abuse may be tested up to one to three times every three months.

Selection of Drug/Drug Class for Testing

In all cases, providers should only test for drugs or drug classes likely to be present based on the member's medical history, current clinical presentation, and illicit drugs that are in common use. In other words, it is **not** medically necessary or reasonable to routinely test for substances (licit or illicit) that are not used in a member's treatment population or, in the instance of illicit drugs, in the community at large.

Procedure Codes

Providers are required to use procedure codes 80305–80307, G0480–G0483, and G0659 when submitting claims for testing for drugs of abuse. Providers should use procedure codes 80305–80307 when submitting claims for presumptive drug tests. Providers are required to select the appropriate code based on the type of presumptive drug test used.

When submitting claims for definitive drug tests, providers should use procedure codes G0480–G0483 or G0659. Code G0659 should be submitted when a simple definitive drug test(s) is performed (refer to HCPCS for the definition of a simple definitive drug test). Definitive drug testing for more than seven drug classes (using procedure codes G0481–G0483) is only appropriate in rare circumstances.

Providers are required to select the appropriate code based on the HCPCS code definition.

Only one of the three presumptive drug tests may be submitted per day, per member. Only one of the five definitive drug tests may be submitted per day, per member.

Claim Submission

Providers should use HCPCS Level I or HCPCS Level II procedure codes and follow CMS (Centers for Medicare and Medicaid Services) guidance in the most recent CLFS (Clinical Laboratory Fee Schedule) Final Rule when submitting claims for drug testing to ForwardHealth. The prescribing/referring/ordering provider is required to be Medicaid-enrolled and to be

indicated on the claim form.

Documentation Requirements

The member's medical record must contain documentation that fully supports the medical necessity for services rendered. This documentation includes, but is not limited to, relevant medical history, physical examination, risk assessment, and results of pertinent diagnostic tests or procedures. The medical record must include:

- A signed and dated member-specific order for each ordered drug test that provides sufficient information to substantiate each testing panel component performed. ("Standing orders," "custom profiles," or "orders to conduct additional testing as needed" are insufficiently detailed and cannot be used to verify medical necessity.)
- A copy of the test results.
- Rationale for ordering a definitive drug test for each drug class tested.
- If a direct-to-definitive drug test is ordered, documentation supporting the inadequacy of presumptive drug testing.

If the provider of the service is not the prescribing/referring/ordering provider, the provider of the service is required to maintain documentation of the lab results and copies of the order for the drug test. The clinical indication/medical necessity for the test must be documented in either the order or the member's medical record.

Topic #494

Tobacco Cessation Drugs and Services

Tobacco cessation services are reimbursed as part of an E&M (evaluation and management) office visit provided by a pharmacist, physician, physician assistant, nurse practitioner, and ancillary staff. Services must be one-on-one, face-to-face between the provider and the member. ForwardHealth does not cover group sessions or telephone conversations between the provider and member under the E&M procedure codes.

Tobacco cessation services covered under ForwardHealth include outpatient substance abuse services or outpatient mental health services, as appropriate.

Tobacco cessation services, as preventive services with an A or B rating from the USPSTF (U.S. Preventive Services Task Force), do not require copays from any member enrolled in BadgerCare Plus or Medicaid.

Ancillary staff can provide tobacco cessation services only when under the direct, on-site supervision of a Medicaid-enrolled physician. When ancillary staff provide tobacco cessation services, Wisconsin Medicaid reimburses up to a level-two office visit (CPT (Current Procedural Terminology) procedure code 99212). The supervising provider is required to be listed as the rendering provider on the claim.

Pharmacists can provide tobacco cessation services within their scope of practice. This includes the following CPT codes:

- 99406 — Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes.
- 99407 — Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes.

Topic #21097

Tobacco Cessation Drugs and Services

Drugs for Tobacco Cessation

BadgerCare Plus, Medicaid, and SeniorCare cover legend drugs for tobacco cessation.

BadgerCare Plus and Medicaid also cover OTC (over-the-counter) nicotine gum, patches, and lozenges.

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 (prior authorization) is required for uses outside the allowable ICD (International Classification of Diseases) diagnoses included in the table below.

Allowable ICD Diagnosis Codes	Descriptions
F17.200	Nicotine dependence, unspecified, uncomplicated
F17.201	Nicotine dependence, unspecified, in remission
F17.203	Nicotine dependence, unspecified, with withdrawal
F17.208	Nicotine dependence, unspecified, with other nicotine-induced disorders
F17.209	Nicotine dependence, unspecified, with unspecified nicotine-induced disorders
F17.210	Nicotine dependence, cigarettes, uncomplicated
F17.211	Nicotine dependence, cigarettes, in remission
F17.213	Nicotine dependence, cigarettes, with withdrawal
F17.218	Nicotine dependence, cigarettes, with other nicotine-induced disorders
F17.219	Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders
F17.220	Nicotine dependence, chewing tobacco, uncomplicated
F17.221	Nicotine dependence, chewing tobacco, in remission
F17.223	Nicotine dependence, chewing tobacco, with withdrawal
F17.228	Nicotine dependence, chewing tobacco, with other nicotine-induced disorders
F17.229	Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders
F17.290	Nicotine dependence, other tobacco product, uncomplicated
F17.291	Nicotine dependence, other tobacco product, in remission
F17.293	Nicotine dependence, other tobacco product, with withdrawal
F17.298	Nicotine dependence, other tobacco product, with other nicotine-induced disorders
F17.299	Nicotine dependence, other tobacco product, with unspecified nicotine-induced disorders
Z72.0	Tobacco use

Topic #3545

Vaccines for Children Program

The federal VFC (Vaccines for Children) Program was created to provide vaccines to eligible children through enrolled public and private providers. The VFC Program is part of a national approach to improving immunization services and levels.

Any child 18 years of age or younger who meets at least one of the following criteria is eligible for the VFC Program:

- Eligible for BadgerCare Plus or Medicaid.
- American Indian or Alaska Native, as defined by the Indian Health Care Improvement Act.

- Uninsured.
- Underinsured. (These children have health insurance but the benefit plan does not cover immunizations. Children in this category may only receive immunizations from a FQHC (federally qualified health center) or an RHC (rural health clinic); they cannot receive immunizations from a private health care provider using a VFC-supplied vaccine.)

When a vaccine becomes available through the VFC Program, the VFC Program notifies providers with clinical information about new vaccines, including the date they may begin ordering the vaccine. On the first of the month following that date, ForwardHealth will begin reimbursing only the administration fee for that vaccine.

Benefits of the Vaccines for Children Program

The VFC Program provides the following benefits:

- Vaccines are provided at no charge to public and private providers to immunize all eligible children.
- Eliminates or reduces vaccine costs as a barrier to the vaccination of eligible children.
- Vaccines recommended by the ACIP (Advisory Committee on Immunization Practices) are automatically covered after approval by the CDC (Centers for Disease Control and Prevention).

Reimbursement for Vaccines Provided to Children

If a vaccine is available through the VFC Program, providers are required to use vaccines from the 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.

Beyfortus (nirsevimab), a monoclonal antibody, is used for the prevention of lower respiratory tract disease caused by RSV (respiratory syncytial virus) in infants or children. Although not a vaccine, the CDC's ACIP voted to include Beyfortus in the VFC Program. Providers are required to obtain Beyfortus for children from the VFC supply. ForwardHealth only reimburses an administration code for Beyfortus supplied through the VFC Program.

Topic #12717

Wearable Cardioverter Defibrillator

Rental of a WCD (wearable cardioverter defibrillator) is a covered service with PA (prior authorization) and is supplied by a DME (durable medical equipment) vendor. The WCD is indicated for members 19 years of age or older who are at high risk for sudden cardiac death. A WCD is used on an outpatient basis and is intended for short-term use under medical supervision.

DME providers are required to request PA. The DME provider is responsible for obtaining the required clinical information from the member's cardiologist to complete the PA.

Reimbursement Policy and Claims

Rental of a WCD includes delivery, setup, and training. Wisconsin Medicaid does not separately reimburse for cables, alarms, electrodes, belts, holsters, lead wires, battery packs, battery charger, monitor, the garment, and other supplies since those items are included in the total rental charge.

Equipment rental is covered only as long as medical necessity exists. Once an ICD (implantable cardioverter defibrillator) is implanted or a heart transplant takes place, the WCD is no longer needed. Providers may not bill for DOS (dates of service) when medical necessity no longer exists.

Evaluation and Management

Topic #481

A Comprehensive Overview

E&M (evaluation and management) services include office visits, hospital visits, and consultations. Specific services include examinations, evaluations, treatments, preventive pediatric and adult health supervision, and similar medical services.

BadgerCare Plus covers most of the categories of E&M services described in CPT (Current Procedural Terminology).

BadgerCare Plus does **not** cover E&M services in the following CPT categories:

- 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 phone conversations between the provider and the member, except for outpatient mental health and substance abuse services. E&M services must be provided to members on a one-on-one basis.

Topic #22557

Collaborative Care Model

ForwardHealth reimburses providers for BHI (behavioral health integration) services identified by the Psychiatric Collaborative Care Management service codes.

CoCM (Collaborative Care Model) is when a primary care provider identifies a member's behavioral health needs and integrates care management support for the member and regular psychiatric inter-specialty consultation with the primary care team.

An episode of care can range from three to 12 months in duration. The episode ends when targeted treatment goals are met, there is a referral for direct psychiatric care, or there is a break in episode (no BHI services for six consecutive months).

Collaborative Care Team

CoCM involves the delivery of integrated care through a collaborative team. The CoCM team must include a treating practitioner, a behavioral care manager, and a consulting psychiatrist. Each provider must meet the requirements in the table below.

Provider	Qualifications	Tasks and Roles
Treating practitioner (billing provider)	• Any provider qualified to use evaluation and management codes, except psychiatrists • Primary care or specialty care providers • Must be enrolled in Wisconsin Medicaid	• Directs the behavioral care manager • Oversees the member's care, including prescribing medications, providing treatments for medical concerns, and making referrals to specialty care when needed • Remains involved through ongoing oversight,

		management, collaboration, and reassessment
Behavioral care manager	• Bachelor's degree in a human service-related field and one year of direct, supervised experience working with individuals in the behavioral health field • Works under the supervision of the billing practitioner • Enrollment in Wisconsin Medicaid **not** required	• Administration of validated rating scales (for example, PHQ-9 scale for depression, GAD-7 for anxiety) • Development of a care plan • Provision of brief psychosocial interventions (for example, motivational interviewing) • Ongoing collaboration with billing practitioner • Consultation with psychiatric consultant • Has continuous relationship with the member • Does not include administrative or clerical staff; time spent in strictly administrative or clerical duties is not counted towards the time threshold to bill BHI codes • Maintenance of registry for tracking patient follow up and progress
Psychiatric consultant	• A licensed psychiatrist, psychiatric advanced practice nurse, or psychiatric-certified physician assistant • Must be enrolled in Wisconsin Medicaid; may be enrolled as a Prescribing, Referring, Ordering professional	• Meets with the primary care team to review the member's treatment plan and status, meets at least weekly • Advises and makes recommendations as needed • If fully enrolled in Wisconsin Medicaid, may render services directly to the member that are separately billed; activities reported separately are not included in the time applied to the collaborative care model

Member Eligibility

Medicaid members of any age are eligible for CoCM services if they have any mental, behavioral health, or psychiatric condition and are working with a treating practitioner whose clinical judgment warrants integrating these behavioral health services for that member. The member's condition(s) could be pre-existing or diagnosed by the treating practitioner. Members may have comorbid, chronic, or other medical conditions that are being managed by the treating practitioner.

Initiating Collaborative Care Model Services

The member must be informed about these services and provide general consent including permission to consult with other CoCM team members, which must be documented in the medical record.

There must be an initiating visit with the treating practitioner prior to the start of CoCM services. For members not seen within a year prior to the commencement of CoCM services, CoCM must be initiated by the treating practitioner during a comprehensive E&M (Evaluation and Management) visit. The initiating visit is not part of the CoCM service and can be separately billed.

Reimbursement

Time spent rendering care management activities is accumulated on a monthly basis and cannot be counted toward any other time-based service. An initial procedure code captures the first hour of service per month and an add-on code captures additional 30-minute increments of service per month. Time spent by a treating practitioner on behavioral health care management activities may be counted towards CoCM time if not billed by another service code. Providers must follow correct coding when billing the CoCM codes.

When CoCM services are provided in an outpatient hospital setting, Medicaid-eligible hospitals may receive separate facility reimbursement for these services.

If the member is enrolled in an HMO or a Family Care Partnership MCO (managed care organization), the treating practitioner is required to bill the time spent on care management activities to the HMO or MCO. Providers should contact the appropriate HMO or MCO for information about managed care implementation of the updated policy and reimbursement amounts.

If the member receives this service on a fee-for-service basis, the treating practitioner is required to follow the fee-for-service claims process. Providers can refer to the interactive maximum allowable fee schedule for fee-for-service reimbursement amounts.

Claim Submission

Billing providers (treating practitioners) submitting claims for CoCM services must include the consulting psychiatrist as the referring provider on the claim and the treating physician as the rendering provider. Providers are required to document all members of the collaborative care team on the member's medical record. Claims submitted for services delivered in a calendar month must reflect the cumulative amount of behavioral health care manager activities, using the last date that the CoCM service was performed in the month as the DOS (date of service) on the claim form. Claims must be submitted **after** the services have been rendered for the entire month.

Note: The actual DOS must be identified in the member's record when documenting each case management activity.

All providers can bill separately for services they provide in conjunction with CoCM services; this time is not included in the calculation of the time spent in providing collaborative care services.

Collaborative Care Model Policy for Community Health Centers

Fee-for-service claims must include HCPCS (Healthcare Common Procedure Coding System) procedure code T1015 in order to receive PPS (prospective payment system) reimbursement. CHCs (Community health centers) should bill for the cumulative month of CoCM services provided and ensure the member's record reflects the entire month's CoCM activities or visits.

Diagnosis Codes

Providers are required to use valid, nationally recognized ICD (International Classification of Diseases) diagnosis codes when submitting claims; however, ForwardHealth does not require a specific diagnosis code for collaborative care management services provided to members.

Place of Service

The claim must include a valid two-digit POS (place of service) code to indicate the setting in which services were provided. Because services may be rendered on multiple DOS and in multiple locations, the biller should report the most frequently used POS on the claim.

Note: The actual POS must be indicated in the member's file when documenting each care management activity.

Procedure Codes

The E&M procedure codes in the following table should be used when providing collaborative care model services.

Procedure Codes for Collaborative Care Management Services	
Code	**Description**
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities*
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent calendar month of behavioral health care manager activities*
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities (list separately in addition to code for primary procedure)*
*CPT (Current Procedural Terminology) codes	

Note: Procedure codes 99492 and 99493 are not reimbursable in the same calendar month for the same provider and member combination.

Topic #23217

Behavioral Health Integration

The general BHI service is for patients with behavioral health conditions. The service is provided by a physician or a qualified health care professional whose scope of practice includes evaluation and management. BHI services can also be provided by a staff member under the supervision of a physician or other qualified health care professional if these elements are included:

- Assessment or follow-up monitoring
- Behavioral health care planning
- Facilitating and coordinating treatment
- Continuity of care with a designated member of the care team

General BHI services must be rendered for at least 20 minutes per month for providers to bill for the services. Providers must create a treatment plan that specifies the elements of the service description, but the plan is not required to be as comprehensive nor have all the functions of CoCM. Like CoCM, BHI services support a member's behavioral health needs but without the requirement to integrate care management support for the member or regular psychiatric inter-specialty consultation with the primary care team.

BHI care management and psychiatric collaborative care management may not be reported by the same professional in the same month.

Procedure Code for General Behavioral Health Integration	
Code	**Description**
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month

Note: General BHI and CoCM services are not reimbursable in the same calendar month for the same provider and member combination.

Topic #482

Concurrent Care

BadgerCare Plus covers E&M (evaluation and management) services provided on the same DOS (date of service) by two or more physicians to a member during an inpatient hospital or nursing home stay only when medical necessity is documented in the member's medical record.

Topic #483

Consultations

Inpatient and outpatient office consultations (CPT (Current Procedural Terminology) procedure codes 99242-99255) are covered when provided to a member at the request of another provider and when medically necessary and appropriate. If an additional request for an opinion or advice regarding the same or a new problem for the same member is received from a second provider and documented in the medical record, the consultation procedure codes may be used again by the consulting provider. Any qualified provider may request a consultation.

If the consulting provider assumes responsibility for management of a portion or all of the member's medical condition, the use of consultation procedure codes is no longer appropriate by that provider. The provider should then use the appropriate level E&M (evaluation and management) code for the POS (place of service).

For a "consultation" initiated by the member or member's family (for example, 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 telehealth, where appropriate. A consultation must always result in a written report that becomes a part of the member's permanent medical record.

Claims Submission

Claims for consultations must include the referring provider's name and NPI (National Provider Identifier).

Topic #484

Critical Care and Prolonged Services

Wisconsin Medicaid reimburses up to four hours per DOS (date of service) for critical care (CPT (Current Procedural Terminology) procedure codes 99291–99292) and prolonged services (CPT procedure code 99360, HCPCS (Healthcare Common Procedure Coding System) procedure codes G2212, G0316, G0317, and G0318).

To request reimbursement for time in excess of four hours per DOS, providers should submit an Adjustment/Reconsideration Request (F-13046 (02/2025)) form for an allowed claim. Supporting clinical documentation (for example, 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 code 99360, HCPCS procedure codes G2212, G0316, G0317, and G0318) if there is face-to-face contact between the provider and the member. Prolonged care services

without face-to-face contact (CPT codes 99358 and 99359) are not covered.

Ambulance Services

Critical care services provided by physicians in an air or ground ambulance are reimbursed under either critical care or prolonged care procedure codes. Claims for services provided in an ambulance must be submitted on a paper claim with a copy of the physician's clinical record attached.

Wisconsin Medicaid does not reimburse physicians for supervising from the home base of a hospital's emergency transportation unit or for supervising in the ambulance.

Topic #3414

Documentation

BadgerCare Plus and Wisconsin Medicaid have adopted the federal CMS (Centers for Medicare & Medicaid Services) 2021 and 2023 "Documentation Guidelines for Evaluation and Management Services," in combination with BadgerCare Plus and Medicaid policy for E&M (evaluation and management) services. Providers are required to present documentation upon request from the Wisconsin Department of Health Services indicating which of the guidelines or BadgerCare Plus policies were utilized for the E&M procedure code that was billed.

When using the CMS documentation guidelines for CPT (Current Procedural Terminology) procedure codes 99202–99205 and 99211–99215, providers are required to retain in their records whether they are billing using MDM (medical decision making) or time. Based on CPT guidelines, if providers bill for time, total time must be reflected in the documentation.

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 website. BadgerCare Plus and Medicaid policy information can be found in service-specific areas of the Online Handbook.

Documentation Requirements

Providers are required to meet the following documentation requirements for E&M services:

- The documentation must accurately reflect the services rendered and support the level of service submitted on the claim.
- Providers are required to document the E&M service at the time the service is provided or as soon as reasonably possible after the service is provided in order to maintain an accurate medical record. All documentation must be complete prior to submission of the claim. Before a service is reimbursed, the provider is required to meet all recordkeeping requirements, according to Wis. Stat. § 49.45(3)(f) and Wis. Admin. Code §§ DHS 106.02(9)(f) and 107.01.
- Providers should only consider medically relevant documentation in determining the appropriate procedure code to bill. The E&M level of service chosen by the provider should not be solely based on the amount of documentation recorded.

All providers who receive reimbursement from Wisconsin Medicaid are required to maintain records that fully document the basis of charges upon which all claims for payment are made, according to Wis. Admin. Code § DHS 106.02(9)(a).

ForwardHealth recognizes certain corrections or changes to a member's medical record when amended legally to accurately reflect the member's medical history. However, if these corrections or changes appear in the medical record following reimbursement determination, only the original medical record will be considered when determining if the reimbursement of services billed was appropriate.

No documentation iterations or section of iterations may be destroyed, deleted, whited-out or rendered illegible. When using a medical EHR (electronic health record) or medical paper record, the provider must be able to generate an unadulterated audit trail

that can verify the information and indicate which actions occurred, when they occurred, and by whom. The date, time, member identification, and user identification must be recorded when information within the record is created, modified, or accessed. Paper-based records must redact previous entries by putting a line through the notation and having it initialed and dated by the user.

Pre-Loaded Text for Electronic Health Records

When using EHR, it is acceptable for the provider to use pre-loaded text or other pre-generated text as long as the required personal documentation is in a secured (password-protected) system and the documentation reflects the actual service rendered. For any pre-loaded or other pre-generated text, the documentation must support that the provider verified the information as part of the professional service rendered.

Personal changes to the pre-loaded or pre-generated text made by the provider generally supports that the information has been verified as part of the professional service billed. Phrases that cannot be verified are not acceptable.

The EHR record must be signed by the renderer of the service.

Topic #485

Emergency Department Services

Physician services providers may receive reimbursement for an emergency E&M (evaluation and management) service (CPT (Current Procedural Terminology) codes 99281-99285) in addition to any surgical procedures or consultations performed by the same rendering provider for the same member on the same DOS (date of service). Providers are required to maintain supporting documentation in their files that justifies the level of the emergency E&M procedure submitted on the claim, as well as the surgical procedure and/or consultation.

Topic #486

Evaluation and Management Services Provided With Surgical Procedures

If a provider performs an office or a hospital visit and a surgical procedure on the same DOS (date of service) for the same member, the provider will receive reimbursement for the surgical procedure only. However, if the surgery is a minor surgery (as determined by Wisconsin Medicaid), the provider may submit an Adjustment/Reconsideration Request (F-13046 (02/2025)) form for the allowed surgery claim to request additional reimbursement for the E&M (evaluation and management) service.

If the E&M service was unrelated to the surgery, the E&M service may be reimbursed if it is billed under a different diagnosis code than the diagnosis code for the surgery.

Topic #487

Family Planning Services

Family planning services are defined as services performed to enable individuals of childbearing age to determine the number and spacing of their children. This includes minors who are sexually active. To enable the state to obtain FFP (federal financial participation) funding for family planning services, the accurate completion of the following elements on the claim is essential:

- An ICD (International Classification of Diseases) diagnosis code from the Z30.011–Z30.9 (Encounter for contraceptive

management) range or modifier FP if a code from the Z30.011–Z30.9 (Encounter for contraceptive management) range is not appropriate and the service provided was related to family planning
- An appropriate diagnosis code reference to the procedure code
- The Family Planning Indicator set to "Y"

Topic #488

Hospital Services

Wisconsin Medicaid ordinarily reimburses physicians for a moderate-level hospital admission procedure code if the physician has provided an E&M (evaluation and management) service or consultation at the highest level of service in the seven days prior to the hospital admission date.

Topic #489

Nursing Home Visits

Wisconsin Medicaid reimburses one routine nursing home visit per calendar month per member. If a physician visits a nursing home member more frequently, medical records must document the medical necessity of the additional visits.

When submitting a claim for a nursing home visit, use the most appropriate CPT (Current Procedural Terminology) procedure code based on the level of service provided.

Topic #490

Observation Care

Observation care is covered. Observation care includes all E&M (evaluation and management) services performed by the admitting physician on the date a member is admitted into observation care. This includes related services provided at other sites and all E&M services provided in conjunction with the admission into observation status.

Only the admitting physician may submit a claim for observation care. Other physicians are required to use another appropriate E&M outpatient or consultation procedure code.

When submitting claims for observation care, use the appropriate CPT (Current Procedural Terminology) procedure code. Providers may refer to the maximum allowable fee schedules for the most current observation care procedure codes. Only one observation care procedure code may be reimbursed per member, per DOS (date of service), per provider. Observation care codes are not reimbursed for members admitted into hospital inpatient care on the same DOS. Only POS (place of service) codes 22 (On Campus — Outpatient Hospital) and 23 (Emergency Room — Hospital) may be indicated on claims for observation care.

Topic #491

Office and Other Outpatient Visits

Established Patient and New Patient Definitions

For the purpose of selecting the appropriate E&M (evaluation and management) code for claim submission, providers are required to follow Evaluation and Management Services Guidelines as defined by CPT (Current Procedural Terminology) for new

and established patients.

Office Visit Daily Limit

Wisconsin Medicaid reimburses only one office visit per member, per rendering provider, per DOS (date of service). However, an E&M office visit may be reimbursed in addition to a preventive medicine visit by the same rendering 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. NCCI (National Correct Coding Initiative) limits apply to services with the same provider on the same day. Providers must follow official guidance about multiple E&M visits.

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 should submit claims for services performed in a physician's office that is located in an on-campus outpatient hospital facility with POS (place of service) code 22 (On Campus—Outpatient Hospital). Physicians should submit claims for services performed in a physician's office that is located in an off-campus outpatient hospital facility with POS code 19 (Off Campus—Outpatient Hospital).

Office Visits and Counseling

A physician or a physician's designee may be reimbursed for counseling (including counseling a member for available courses of treatment) using E&M office visit procedure codes 99202–99215 and G2212, even if counseling was the only service provided during the visit. Counseling may include the discussion of treatment options that are not covered (for example, experimental services).

Topic #492

Preventive Medicine Services

Preventive medicine services are those office visits that relate to preventive medicine E&M (evaluation and management) of infants, children, adolescents, and adults. Preventive medicine services include:

- 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 screens.

HealthCheck Screens

HealthCheck is the term used for EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) in Wisconsin. HealthCheck

services consist of an age-appropriate comprehensive health screen of Medicaid members under 21 years of age that includes **all** the following:

- A comprehensive health and developmental history, including:
  - A health history
  - A nutritional assessment
  - A developmental-behavorial assessment
  - Health education and anticipatory guidance for the member and caregiver
- A comprehensive unclothed physical exam
- A vision screen
- A hearing screen
- An oral assessment, plus referral to a dentist beginning when the first tooth erupts or by age 1
- Appropriate immunizations
- Appropriate laboratory tests (including blood lead level testing when appropriate for age)

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.

HealthCheck Interperiodic Visits

An interperiodic screen can be problem-focused or may include any or all components of the comprehensive screen. These visits may be required to diagnose a new illness or condition or to determine whether a previously diagnosed illness or condition requires services. Examples of interperiodic screens include:

- Immunizations
- Retesting for an elevated blood lead level
- Retesting for a low hematocrit
- Addressing nutrition concerns

Providers should submit claims for interperiodic visits using the appropriate office visit procedure code (99202–99205, 99211–99215, G2212) along with a preventive medicine diagnosis code.

HealthCheck Other Services

Wisconsin Medicaid covers most diagnostic and intervention services a member may need. However, federal law requires that states provide any additional health care services that are coverable under the federal Medicaid program and found to be medically necessary to treat, correct, or reduce illnesses and conditions discovered regardless of whether or not the service is covered in a state's Medicaid program. HealthCheck Other Services is Wisconsin's term for this federal requirement.

The requested service must be allowable under federal Medicaid law, per § 1905(a) of the Social Security Act, and must be medically necessary and reasonable for the member to be covered by Wisconsin Medicaid. Most HealthCheck Other Services require PA (prior authorization), per Wis. Admin. Code § DHS 107.02.

Topic #3451

Primary Care Treatment and Follow-up Care for Mental Health and Substance Abuse

Initial primary care treatment and follow-up care are covered for members with mental health and/or substance abuse needs provided by primary care physicians, physician assistants, and nurse practitioners. Wisconsin Medicaid will reimburse the previously listed providers for E&M (evaluation and management) outpatient office visits (CPT (Current Procedural Terminology) procedure codes 99202–99205 and 99211–99215 and HCPCS (Healthcare Common Procedure Coding System) procedure code G2212) with an ICD (International Classification of Diseases) diagnosis code applicable for mental health and/or substance abuse services. As a reminder, these services may be eligible for HPSAs (Health Professional Shortage Areas) and pediatric enhanced reimbursements.

Refer to the federal CMS (Centers for Medicare & Medicaid Services) "2021 Documentation Guidelines for Evaluation and Management Services" for determining the appropriate level of E&M services.

Since counseling may constitute a significant portion of the E&M services delivered to a member with mental health and/or substance abuse diagnoses, providers are required to fully document the percentage of the E&M time that involved counseling. This documentation is necessary to justify the level of E&M visit.

Claims for services delivered by ancillary staff under the direct, on-site supervision of a primary care physician must be submitted under the NPI (National Provider Identifier) of the supervising physician. Coverage and reimbursement are limited to CPT code 99211 or 99212 as appropriate.

If mental health primary care services are provided under CoCM (Collaborative Care Model), providers should use the appropriate CPT or HCPCS codes when billing for those services.

HealthCheck Other Services

Topic #22

Definition of HealthCheck Other Services

HealthCheck is the term used for EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) in Wisconsin. The HealthCheck benefit provides periodic, comprehensive health screening exams (also known as well child checks), as well as interperiodic screens, outreach and case management, and additional medically necessary services (referred to as HealthCheck Other Services) for members under 21 years of age.

Wisconsin Medicaid covers most diagnostic and intervention services a member may need. However, federal law requires that states provide any additional health care services that are coverable under the federal Medicaid program and found to be medically necessary to treat, correct, or reduce illnesses and conditions discovered regardless of whether or not the service is covered in a state's Medicaid program. HealthCheck Other Services is Wisconsin's term for this federal requirement.

The requested service must be allowable under federal Medicaid law, per § 1905(a) of the Social Security Act, and must be medically necessary and reasonable for the member to be covered by Wisconsin Medicaid, per Wis. Admin. Code § DHS 107.02(3)(e). Most HealthCheck Other Services require PA (prior authorization) per Wis. Admin. Code § DHS 107.02.

Topic #1

Prior Authorization for HealthCheck Other Services

Providers submitting PA (prior authorization) requests for HealthCheck Other Services should review the two types of PA requests. The following types of PA requests have their own submission requirements:

- Requests for exceptions to coverage limitations
- Requests for federally allowable Medicaid services not routinely covered by Wisconsin Medicaid

PA Submission Requirements for Exceptions to Coverage Limitations

HealthCheck Other Services may additionally cover established Medicaid health care services that are limited in coverage for members under 21 years of age.

If a PA request is submitted requesting additional coverage for a benefit where there is established policy, the request is automatically processed under the HealthCheck Other Services benefit to evaluate whether the requested service is likely to correct or ameliorate the member's condition, including maintaining current status or preventing regression.

Examples of coverage limitations include service amounts that are prohibited by policy, or the requested service is not expected to result in a favorable improvement in the member's condition or diagnosis.

Every PA request for a member under age 21 is first processed according to standard Medicaid guidelines and then reviewed under HealthCheck Other Services guidelines. For these reasons, providers do **not** need to take additional action to identify the PA request as a HealthCheck Other Services request.

If an established benefit will be requested at a level that exceeds Wisconsin Medicaid coverage limits, in addition to the required PA documentation detailed in the appropriate service area of the Online Handbook, the request should provide:

- The rationale detailing why standard coverage is not considered acceptable to address the identified condition.
- The rationale detailing why the requested service is needed to correct or ameliorate the member's condition.

PA Submission Requirements for Services Not Routinely Covered by Wisconsin Medicaid

HealthCheck Other Services allows coverage of health care services that are not routinely covered by Wisconsin Medicaid, but are federally allowable and medically necessary to maintain, improve, or correct the member's physical and mental health, per § 1905(a) of the Social Security Act. These HealthCheck Other Services require PA since the determination of medical necessity is made on a case-by-case basis depending on the needs of the member.

If a PA request is submitted requesting coverage for a service that does not have established policy and is not an exception to coverage limitations, the provider is required to identify the PA as a HealthCheck Other Services request by **checking the HealthCheck Other Services box** and submit this information:

- A current, valid order or prescription for the service being requested:
  - Prescriptions are valid for 12 or fewer months from the date of the signature (depending on the service area).
  - Updated prescriptions may be required more frequently for some benefits.
- A completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026)), for most service areas, including:
  - For Element 1, **check the HealthCheck Other Services box.**
  - For Element 19, enter the procedure code that most accurately describes the service, even if the code is not ordinarily covered by Wisconsin Medicaid. Unlisted procedure codes can be requested if the service is not accurately described by existing procedure codes.
  - For Element 20, enter informational procedure code modifier EP (Service provided as part of Medicaid early periodic screening diagnosis and treatment [EPSDT] program) to indicate that the service is requested as a HealthCheck Other Services benefit.
  - For Element 22, include the description of the service.
- For dental providers, instead of the PA/RF, a completed PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/2012)) and PA/DGA (Prior Authorization/Drug Attachment (01/2024)).
- A PA attachment form(s) for the related service area, if known, or clinical documentation substantiating the medical necessity of the requested procedure code and:
  - The rationale detailing why services typically covered by Wisconsin Medicaid are not considered acceptable to address the identified condition or why services were discontinued.
  - The rationale detailing why the requested service is needed to correct or ameliorate the member's condition.

  Note: Providers may call Provider Services to determine the appropriate PA attachment.

- Evidence the requested service is clinically effective and not harmful (If the requested service is new to Wisconsin Medicaid, additional documentation regarding current research and/or safety of the intervention may be submitted.)
- The MSRP (manufacturer's suggested retail price) for requested equipment or supplies
- The 11-digit NDC (National Drug Code) for any requested OTC (over-the-counter) drugs on pharmacy PA requests

Providers may call Provider Services for more information about HealthCheck Other Services.

Topic #41

Requirements

For a service to be reimbursed through HealthCheck Other Services, the following requirements must be met:

- The service is provided to a member who is under 21 years of age.
- The service is coverable under federal Medicaid law.
- The service is medically necessary and reasonable.
- The service is prior authorized before it is provided.
- Services currently available are not considered acceptable to treat the identified condition.

ForwardHealth has the authority to do all of the following:

- Review the medical necessity of all requests.
- Establish criteria for the provision of such services.
- Determine the amount, duration, and scope of services as long as the authorized amount is reasonable and maintains the preventive intent of the HealthCheck benefit.

HealthCheck Other Services does not include reimbursement in excess of ForwardHealth published maximum allowable fees.

All PA (prior authorization) requests must follow NCCI (National Correct Coding Initiative) guidelines.

Medicine Services

Topic #493

Allergy Tests

Claims for allergy tests must include the appropriate CPT (Current Procedural Terminology) procedure code(s) and the quantities of items provided or tests performed.

Topic #495

Audiometry

Basic comprehensive audiometry includes all of the following:

- Pure tone air audiometry
- Pure tone bone audiometry
- Speech audiometry, threshold
- Speech audiometry, discrimination

If a claim is submitted for basic comprehensive audiometry testing in combination with any of the individual components of the comprehensive test for the same member on the same DOS (date of service), only the comprehensive audiometry testing is reimbursed.

A physician referring a member to a hearing instrument specialist for a hearing aid must complete a PA/POR (Prior Authorization/Physician Otological Report, F-11019 (07/2012)). The physician should give page one (or a copy) of the PA/POR to the member and keep page two (or a copy of it) in the member's medical records.

Topic #496

Biofeedback

Wisconsin Medicaid reimburses physicians and physician assistants for biofeedback training, procedure codes 90901, 90912, and 90913. Only psychiatrists may be reimbursed for individual psychophysiological therapy incorporating biofeedback, procedure codes 90875 and 90876. Other service areas of this website contain more information about mental health and substance abuse services.

Topic #502

Certificate of Need Requirements for Members Admitted to an Institution for Mental Disease

Federal and state regulations require IMDs (Institutions for Mental Disease) to conduct and document a CON (Certification of Need) assessment for all members under the age of 21 who are admitted for elective/urgent or emergency psychiatric or substance abuse treatment services.

The CON assessments must be completed by a team of professionals, including at least one physician, working in cooperation with the hospital. One of the following completed forms must be readily available for ERO (external review organization) or Wisconsin DHS (Department of Health Services) review:

- Certification of Need for Elective/Urgent Psychiatric/Substance Abuse Admissions to Hospital Institutions for Mental Disease for Members Under Age 21 (F-11047 (02/2009))
- Certification of Need for Emergency Psychiatric/Substance Abuse Admissions to Hospital Institutions for Mental Disease for Members Under Age 21 and in Case of Medicaid Determination After Admission (F-11048 (02/2009))

Topic #497

Chemotherapy

When chemotherapy for a malignant disease is provided in a physician's office, separate reimbursement is allowed for the following:

- E&M (evaluation and management) visits
- The drug, including injection of the drug
- Therapeutic infusions
- Supplies
- Physician-administered oral antiemetic drugs

Use procedure code 99070 for supplies and materials provided by the physician.

Chemotherapy drugs (HCPCS (Healthcare Common Procedure Coding System) codes J9000–J9999) are covered. Reimbursement for these procedure codes includes the cost of the drug and the charge for administering the drug. (If the physician's office does not supply the drug, use procedure code 90782 or 90784 on claims for the injection. Use the appropriate procedure code for the infusion when performed by the physician.)

When chemotherapy for a malignancy is provided in an inpatient hospital, outpatient hospital, or nursing home setting, physician services providers may receive reimbursement for the E&M visit only.

Antiemetic Drugs

Physician-administered antiemetic drugs for members receiving chemotherapy are covered. The appropriate HCPCS "Q" code should be indicated when submitting a claim for a physician-administered oral antiemetic 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 antiemetic drug given to a member for the same DOS (date of service).

Topic #499

End-Stage Renal Disease Services

Physician services providers should submit claims with CPT (Current Procedural Terminology) procedure codes 90951–90970 for professional ESRD (end-stage renal disease)-related services. These services may be reimbursed once per calendar month per member. Member copays are deducted for these services as appropriate.

Dialysis Treatment Provided Outside the Member's Home

Providers should submit claims with procedure codes 90951–90962 for ESRD members who are receiving dialysis treatment

somewhere other than in their home. Providers should indicate the appropriate procedure code based on the age of the member and the number of face-to-face visits per month. The visits may occur in the physician's office, an outpatient hospital or other outpatient setting, or the member's home, as well as the dialysis facility. If the visits occur in multiple locations, providers should indicate on claims the POS (place of service) code where most of the visits occurred.

If an ESRD member is hospitalized during the month, the physician may submit a claim with the code that reflects the appropriate number of face-to-face visits that occurred during the month on days when the member was not in the hospital.

Indicate the first DOS of the month and always indicate a quantity of "1.0" to represent a month of care. Do not report the specific dates of each dialysis session on the claim.

Home Dialysis Members

Providers should submit claims with procedure codes 90963–90966 for home dialysis ESRD members. The procedure codes differ according to age, but do not specify the frequency of required visits per month.

When submitting claims for these procedure codes, report the first DOS of the month and always indicate a quantity of "1.0" to represent a month of care. Do not report the specific dates of each dialysis session.

Home Dialysis Members Who Are Hospitalized

Procedure codes 90967–90970 are for home dialysis ESRD members who are hospitalized during the month.

These procedure codes can be used to report daily management for the days the member is not in the hospital. For example, if a home dialysis member is in the hospital for 10 days and is cared for at home the other 20 days during the month, then 20 units of one of the codes would be used. If a home dialysis member receives dialysis in a dialysis center or other facility during the month, the physician is still reimbursed for the management fee and may not be reimbursed for procedure codes 90951–90962.

Paper Claims

When submitting claims for procedure codes 90967–90970, report the DOS for ESRD-related care within a calendar month, with the first DOS as the "From DOS" and the last DOS as the "To DOS." Indicate the actual number of days under the physician's care within the calendar month as the quantity.

Electronic Billing

Providers submitting 837P (837 Health Care Claim: Professional) transactions should indicate individual DOS per detail line. Providers may indicate a range of dates per detail line using the 837P transaction only when the service is performed on consecutive days.

Topic #500

Evoked Potentials

Only audiologists and physicians with specialties of neurology, otolaryngology, ophthalmology, physical medicine and rehabilitation, anesthesiology, and psychiatry can be reimbursed for evoked potential testing.

The following evoked potential tests are covered:

- Brain stem evoked response recording
- Visual evoked potential study

- Somatosensory testing
- Intraoperative neurophysiological testing reimbursed by the hour

These evoked potential tests are allowed once per day per member. When two or more types of evoked potential tests are performed on the same DOS (date of service) (for example, brain stem and visual), reimbursement is 100% of the Medicaid maximum allowable fee for the first test, with a lesser amount for the second and subsequent tests.

Topic #501

Fluoride — Topical Applications

Topical application of fluoride to a child's teeth is a safe and effective way to prevent tooth decay as part of a comprehensive oral health program.

Coverage

Wisconsin Medicaid recommends that children under age 5 who have erupted teeth receive topical fluoride treatment. Children at low or moderate risk of early childhood caries should receive one or two applications per year; children at higher risk should receive three or four applications per year.

The most accepted mode of fluoride delivery in children under age 5 is a fluoride varnish. OTC (over-the-counter) mouth rinses are not covered.

Submitting Claims

When submitting claims for topical fluoride treatment, medical providers should indicate procedure code 99188 (Application of topical fluoride varnish by a physician or other qualified health care professional) if fluoride varnish is used or D1208 (Topical application of fluoride) if topical fluoride-excluding varnish is used. Providers may also submit HealthCheck and office visit HCPCS (Healthcare Common Procedure Coding System) procedure codes in addition to the above services if appropriate.

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 (for example, nurse practitioners) are required to follow certain billing procedures.

Wisconsin Medicaid will separately reimburse providers for the appropriate level office visit or preventive visit at which the fluoride application was performed.

Training Materials

An Oral Health Provider Training guide describing how providers may perform lift-the-lip oral screenings, apply fluoride varnish to a small child's teeth, and provide basic oral health guidance to parents is available.

Topic #504

Laboratory Test Preparation and Handling Fees

If a physician obtains a specimen and forwards it to an outside laboratory, only the outside laboratory that performs the procedure may be reimbursed for the procedure. The physician who forwards the specimen is only reimbursed a handling fee.

When forwarding a specimen from a physician's office to an outside laboratory, submit claims for preparation and handling fees using procedure code 99000. When forwarding a specimen from someplace other than a physician's office to a laboratory, submit claims using procedure code 99001. It is not necessary to indicate the specific laboratory test performed on the claim.

A handling fee is not separately reimbursable if the physician is reimbursed for the professional and/or technical component of the laboratory test.

Additional Limitations

The following are additional limitations on reimbursement for lab handling fees:

- One lab handling fee is reimbursed per provider, per member, per outside laboratory, per DOS (date of service), regardless of the number of specimens sent to the laboratory.
- More than one handling fee is reimbursed when specimens are sent to two or more laboratories for one member on the same DOS. Indicate the number of laboratories and the total charges on the claim. The name of the laboratory does not need to be indicated on the claim; however, this information must be documented in the provider's records.
- The DOS must be the date the specimen is obtained from the member.

Topic #505

Mental Health Services

Except for biofeedback and pharmacological management, Mental Health Services are reimbursable only for Medicaid-enrolled physicians with a psychiatric specialty.

Topic #506

Physician-Administered Drugs

Procedure codes for Medicaid-covered physician-administered drugs are listed in the physician services maximum allowable fee schedule. Providers should use the appropriate fee schedule in conjunction with the most recent HCPCS (Healthcare Common Procedure Coding System) coding book for descriptions.

Diagnosis Restrictions for Physician-Administered Drugs

Diagnosis restrictions that apply to NDCs (National Drug Codes) also apply to corresponding HCPCS codes when billed as physician-administered drugs. Wisconsin Medicaid requires a valid and acceptable ICD (International Classification of Diseases) diagnosis code on claims for selected physician-administered drugs. A ForwardHealth-allowed diagnosis code must be indicated on claims for diagnosis-restricted physician-administered drugs.

The Diagnosis Code-Restricted Physician-Administered Drugs data table contains information about diagnosis-restricted physician-administered drugs. For each drug, the corresponding HCPCS procedure code, ICD diagnosis code(s), and disease description(s) are listed. If the member's diagnosis is not an allowable diagnosis for the code listed on the Diagnosis Code-Restricted Physician-Administered Drugs data table, prescribers are required to obtain PA (prior authorization).

If a prescriber orders a physician-administered drug with a diagnosis outside the ForwardHealth-allowed diagnosis for a drug, the prescriber must submit peer-reviewed medical literature to support the proven efficacy and safety of the requested use of the drug. The prescriber also must include documentation of previous treatments and detailed reasons why other covered drug treatments were discontinued or not used. Medical records should be provided as necessary to support the PA request.

PA Requirements

Prescribers are required to obtain PA for certain Medicaid-allowable drugs and physician-administered drugs that are **not** provided with an allowable diagnosis code. Prescribers are required to use the PA/PAD (Prior Authorization/Physician-Administered Drug Attachment, F-11034 (07/2022)) form along with the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) to request PA.

Only the diagnosis codes included in the diagnosis code-restricted physician-administered drugs data 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 ((02/12)) and attach the following information:

- Name of drug
- NDC
- Dosage
- Quantity (for example, vials, milliliters, milligrams)

Topic #508

Screenings

Medicaid-allowable screening procedure codes are identified in the allowable procedure codes list for physician services providers. The following are general principles for coverage of screening and diagnostic procedures:

- Wisconsin Medicaid reimburses both screening and diagnostic tests and procedures under the appropriate procedure codes.
- Reimbursement for office visits is included with the reimbursement for surgical procedures, whether diagnostic or screening (for example, 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 (for example, a preventive code). For example, a claim for a glaucoma screening could indicate ICD (International Classification of Diseases) diagnosis code Z13.5 (Encounter for screening for eye and ear disorders).

Diagnostic Procedures

Providers should indicate diagnostic procedure codes when submitting claims in the following instances:

- There are symptoms or other indications of a medical problem.
- To confirm a previous diagnosis.
- There is a personal history of a medical problem or related condition.
- During a screening, a problem or medical condition is found and a biopsy or other sample is taken for further study and analysis.

Service-Specific Information

The following information gives details about each kind of screening and/or when to request reimbursement for diagnostic services. Refer to CPT (Current Procedural Terminology) for diagnostic procedure codes.

Breast Cancer - Mammography

Wisconsin Medicaid does not have limitations on the frequency of mammography. Providers may be reimbursed for both a screening mammography and a diagnostic mammography for the same patient on the same DOS if they are performed as separate films. Reasons for the separate procedures must be documented in the member's medical record.

Colorectal Cancer

Providers may submit claims for a variety of colorectal cancer screening or diagnostic tests, including laboratory tests, flexible sigmoidoscopy, proctosigmoidoscopy, barium enema, and colonoscopy. Providers should indicate the HCPCS (Healthcare Common Procedure Coding System) or CPT procedure code that best reflects the nature of the procedure. If abnormalities (for example, polyps) are found during a screening colonoscopy or sigmoidoscopy and biopsies taken or other coverage criteria are met (for example, 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 45 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 45 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 FAP (familial adenomatous polyposis) or HNPCC (hereditary nonpolyposis colon cancer)

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 smear lab tests. 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.

Obtaining of a pap smear and transportation of the specimen to a laboratory is included in the appropriate E&M (evaluation and management) service and should not be billed separately.

Pelvic and Breast Exams

Wisconsin Medicaid reimburses for a screening pelvic and breast exam if it is the only procedure performed on that DOS. A pelvic and breast exam (HCPCS procedure code G0101) performed during a routine physical examination or a problem-oriented office visit is not separately reimbursable but is included in the reimbursement for the physical examination or office visit. When using an E&M office visit procedure code, the time and resources for the pelvic and breast exam should be factored into the determination of the appropriate level for the office visit.

Prostate Cancer

The following tests and procedures provided to an individual for the early detection and monitoring of prostate cancer and related conditions are covered:

- Screening DRE (Digital Rectal Examination) — This test is a routine clinical examination of an asymptomatic individual's prostate for nodules or other abnormalities of the prostate.
- Screening PSA (Prostate Specific Antigen) Blood Test — This test detects the marker for adenocarcinoma of the prostate.
- Diagnostic PSA Blood Test — This test is used when there is a diagnosis or history of prostate cancer or other prostate conditions for which the test is a reliable indicator.

Reimbursement for a DRE is included in the reimbursement for a covered E&M or preventive medical examination when the services are furnished to a member on the same day. If the DRE is the only service provided, the applicable procedure code may be reimbursed. The screening and diagnostic PSA tests are separately reimbursable when performed on the same DOS as an E&M or preventive medical exam.

Topic #509

Substance Abuse Services

The following substance abuse services are covered:

- Individual substance abuse therapy
- Family substance abuse therapy
- Group substance abuse therapy

Physicians interested in providing substance abuse services may refer to the Outpatient Substance Abuse service area or call Provider Services.

Topic #511

Weight Management Services

Weight management services (for example, diet clinics, obesity programs, weight loss programs) are reimbursable only if performed by or under the direct, on-site supervision of a provider and if performed in an allowable place of service. Weight management services exceeding five visits per calendar year require PA (prior authorization). Prescription drugs prescribed for weight loss also require PA. (The Pharmacy service area has additional information about prescription drug PA requirements.)

Submit claims for weight management services with the appropriate E&M (evaluation and management) procedure code. For weight management services, food supplements, and dietary supplies (for example, liquid or powdered diet foods or supplements, OTC (over-the-counter) diet pills, and vitamins) that are dispensed during an office visit are not separately reimbursable by Wisconsin Medicaid.

Mental Health and Substance Abuse Screening for Pregnant Women

Topic #4442

An Overview

Definition of the Benefit

This benefit is for pregnant women enrolled in BadgerCare Plus and Wisconsin Medicaid. All policies and procedures are the same for BadgerCare Plus and Wisconsin Medicaid unless otherwise specified. Women enrolled in an HMO must receive the services through the HMO. These services do not require PA (prior authorization) and are not subject to copayment under BadgerCare Plus and Wisconsin Medicaid.

The purpose of this benefit is to identify and assist pregnant women at risk for mental health or substance abuse problems during pregnancy. The benefit has two components:

- Screening for mental health (for example, depression and/or trauma) and/or substance abuse problems
- Brief preventive mental health counseling and/or substance abuse intervention for pregnant women identified as being at risk for experiencing mental health or substance abuse disorders

These are preventive services available to members with a verified pregnancy. These services are not intended to treat women previously diagnosed with a mental health or substance abuse disorder or to treat women already receiving treatment through mental health, substance abuse, or prenatal care coordination services.

The mental health screening and preventive counseling are designed to prevent mental health disorders from developing or worsening in severity during the pregnancy and the postpartum period. The substance abuse screening and intervention services are designed to help women stay alcohol and drug free during the pregnancy.

Women identified through the screening process as likely to be experiencing mental health disorders and women identified as likely to be dependent on alcohol or other drugs should be referred to an appropriate enrolled mental health or substance abuse program.

BHI (Behavioral health integration) services provided through CoCM (Collaborative Care Model) require separate billing procedures.

Mental Health and Substance Abuse Screening

Providers are required to use an in-depth evidence-based tool to identify women at risk for mental health, substance abuse, or trauma-related problems; however, there is no requirement for a specific screening tool.

Mental health screening tools available to providers include the following:

- EPDS (Edinburgh Postnatal Depression Scale)
- BDI-II (Beck Depression Inventory-II)
- CES-D (Center for Epidemiologic Studies Depression Scale)
- The nine item depression scale of the PHQ-9 (Patient Health Questionnaire)

Substance abuse screening tools available to providers include the following:

- The 5-Ps Prenatal Substance Abuse Screen for Alcohol, Drugs, and Tobacco
- T-ACE (Tolerance, Annoyance, Cut down, Eye opener) screen
- TWEAK (Tolerance, Worry, Eye opener, Amnesia, Cut down) screen
- The ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test)

Preventive Mental Health Counseling and Substance Abuse Intervention

Brief preventive mental health counseling and substance abuse intervention services are covered for pregnant women who are identified through the use of an evidence-based screening tool as being at risk for mental health or substance abuse disorders.

Providers are required to use effective strategies for the counseling and intervention services although BadgerCare Plus and Wisconsin Medicaid are not endorsing a specific approach.

Examples of effective strategies for treatment include the following:

- SBIRT (Screening, Brief Intervention and Referral to Treatment)
- My Baby & Me (a program that addresses alcohol cessation in pregnant women using specific intervention and counseling strategies)

Topic #4446

Coverage Limitations

Mental Health and Substance Abuse Screening

The screening (HCPCS (Healthcare Common Procedure Coding System) procedure code H0002 with modifier HE or HF) is not considered part of the mental health and substance abuse services available under BadgerCare Plus or Wisconsin Medicaid. The screening does not require PA (prior authorization) and is not counted towards any service limitations or PA thresholds for those services.

Preventive Mental Health Counseling and Substance Abuse Intervention

The counseling/intervention services (HCPCS procedure code H0004 with modifier HE or HF) are limited to four hours (or 16 units of service, each unit equivalent to 15 minutes) per member per pregnancy. If a member receives both preventive mental health counseling and substance abuse intervention services, the hours of both services count toward the four-hour limit. Additionally, only one hour (up to four units of service) can be billed on one DOS (date of service). The counseling and intervention services must be provided on the same DOS or on a later DOS than the screening.

These services are covered during the pregnancy and up to 60 days postpartum.

These services are not considered part of the mental health and substance abuse services available under BadgerCare Plus or Wisconsin Medicaid and are not counted towards any service limitations or PA thresholds for those services.

Behavioral Health Integration Services

BHI (Behavioral health integration) services provided through CoCM (Collaborative Care Model) require separate billing procedures.

Topic #4444

Documentation Requirements

Providers are required to retain documentation that the member receiving these services was pregnant on the DOS (date of service). Providers are also required to keep a copy of the completed screening tool(s) in the member's file. If an individual other than a certified or licensed health care professional provides services, the provider is required to retain documents concerning that individual's education, training, and supervision.

Topic #4443

Eligible Providers

Early detection of potential mental health, trauma, or substance abuse problems is crucial to successfully treating pregnant women. It is also important for women to obtain referrals for follow-up care. In order to accomplish these goals, BadgerCare Plus and Wisconsin Medicaid are allowing a wide range of providers to administer these services.

The screening, counseling, and intervention services must be provided by a certified or licensed health care professional or provided by an individual under the direction of a licensed health care professional. In addition to meeting the supervision requirement, individuals who are not licensed health care professionals must have appropriate training or a combination of training and work experience in order to administer any of these services.

Providers Eligible for Reimbursement of Mental Health and Substance Abuse Screening, Preventive Mental Health Counseling, and Substance Abuse Intervention Services for Pregnant Women

The following table lists provider types eligible for reimbursement for administering mental health and substance abuse screening, preventive mental health counseling, and substance abuse intervention services for pregnant women enrolled in BadgerCare Plus and Wisconsin Medicaid.

Provider Type	Mental Health or Substance Abuse Screening (H0002 with modifier HE or HF)*	Mental Health Preventive Counseling (H0004 with modifier HE)*	Substance Abuse Intervention (H0004 with modifier HF)*
Pharmacists	Not allowed	Allowed	Allowed
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
AODA counselors in outpatient mental health or substance abuse clinics	Not allowed	Not allowed	Allowed
Advanced practice nurse prescribers with psychiatric specialty	Allowed	Allowed	Allowed

Nurse midwives	Allowed	Not allowed	Allowed
Nurse practitioners	Allowed	Allowed	Allowed
Prenatal care coordination agencies	Allowed	Not allowed	Allowed
Crisis intervention agencies	Allowed	Allowed	Allowed
HealthCheck providers (not including Case Management Only agencies)	Allowed	Not allowed	Allowed

* This table includes the HCPCS (Healthcare Common Procedure Coding System) procedure codes and modifiers that correspond with the screening, counseling, and intervention services.

Topic #4445

Procedure Codes and Modifiers

The following tables list the HCPCS (Healthcare Common Procedure Coding System) procedure codes and applicable modifiers that providers are required to use when submitting claims for mental health and substance abuse screening, preventive mental health counseling, and substance abuse intervention services for pregnant women enrolled in BadgerCare Plus or Wisconsin Medicaid. Not all providers may be reimbursed for a particular service.

Mental Health and Substance Abuse Screening and Preventive Counseling/Intervention Services for Pregnant Women					
Procedure Code	**Description**	**Required Modifier**	**Limitations**	**Allowable ICD (International Classification of Diseases) Diagnosis**	**Allowable Place of Service**
H0002 Mental Health and Substance Abuse Screening	Behavioral health screening to determine eligibility for admission to treatment program (Unit equals one, regardless of time)	HE (Mental health program) or HF (Substance abuse program)	No limit to the number of screenings per pregnancy.	Z36.9 (Encounter for antenatal screening unspecified)	03, 04, 05, 06, 07, 08, 11, 12, 13, 14, 15, 19, 20, 21*, 22, 23, 25, 26, 27, 49, 50, 51, 56, 57, 60, 61, 71, 72
H0004 Preventive Mental Health Counseling and Substance Abuse Intervention	Behavioral health counseling and therapy, per 15 minutes (Unit equals 15 minutes)	Required HE (Mental health program) HF (Substance abuse program)	Limited to 16 units per member per pregnancy. Only four units of service are allowed per DOS. A screening (H0002 with modifier HE or HF) must be administered on or before the DOS for this procedure.	Z71.89 (Other specified counseling)	03, 04, 05, 06, 07, 08, 11, 12, 13, 14, 15, 19, 20, 21*, 22, 23, 25, 26, 27, 49, 50, 51, 56, 57, 60, 61, 71, 72

*POS (place of service) code 21 (inpatient hospital) is not allowed for substance abuse counselors and Master's-level mental health providers.

Noncovered Services

Topic #68

Definition of Noncovered Services

A noncovered service is a service, item, or supply for which reimbursement is not available. Wis. Admin. Code § DHS 101.03 (103) and Wis. Admin. Code ch. 107 contain more information about noncovered services. In addition, Wis. Admin. Code § DHS 107.03 contains a general list of noncovered services.

Topic #567

Experimental Services

Wisconsin Medicaid does not cover services that are considered to be experimental in nature. A service is considered experimental when Wisconsin Medicaid determines that the procedure or service is not an effective or proven treatment for the condition for which it is intended.

Wisconsin Medicaid resolves questions relative to the experimental or nonexperimental nature of a procedure based on the following, as appropriate:

- The judgment of the medical community
- The extent to which other health insurance sources cover a service
- The current judgment of experts in the applicable medical specialty area
- The judgment of a committee formed by the ERO (external review organization) at the request of Wisconsin Medicaid

Topic #104

Member Payment for Noncovered Services

A provider may collect payment from a member for noncovered services if certain conditions are met.

Providers may not collect payment from a member (or authorized person acting on behalf of the member) for certain noncovered services or activities provided in connection with covered services, including:

- Charges for missed appointments
- Charges for phone calls
- Charges for time involved in completing necessary forms, claims, or reports
- Translation services

Missed Appointments

Federal CMS (Centers for Medicare and Medicaid Services) does not allow state Medicaid programs to permit providers to collect payment from a member, or authorized person acting on behalf of the member, for a missed appointment.

Avoiding Missed Appointments

ForwardHealth offers the following suggestions to help avoid missed appointments:

- Remind members of upcoming appointments (by phone or postcard) before scheduled appointments.
- If a member needs help getting transportation to a medical appointment, encourage the member to call the NEMT (non-emergency medical transportation) manager contracted with Wisconsin DHS (Department of Health Services). Most Medicaid and BadgerCare Plus members can receive NEMT services through the NEMT manager if they have no other way to receive a ride. Refer to the NEMT service area for more information.
- If the appointment is made through the HealthCheck screening or targeted case management programs, encourage the staff from those programs to ensure that the scheduled appointments are kept.

Translation and Interpretive Services

Translation services, which refer to translation of the written word, 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.

Interpretive services, which refer to interpretation of the spoken word or sign language, are a covered service. More information on interpretive services can be found in the Interpretive Services topic.

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
201 E Washington Ave Room B300
PO Box 7850
Madison WI 53707-7850

Topic #16977

Noncovered Genetic Testing

Wisconsin Medicaid and BadgerCare Plus do not cover genetic testing in situations where the results would not have a clinically useful impact on health outcomes.

Wisconsin Medicaid and BadgerCare Plus do not cover full genome and exome sequencing.

Topic #23343

Noncovered Services for Pharmacists

ForwardHealth will not reimburse noncovered services, as defined in Wis. Admin. Code § DHS 107.03.

Other examples of noncovered services for Medicaid-enrolled pharmacists include:

- Services in which ForwardHealth policy was not followed
- Services provided outside the pharmacist's scope of practice
- Services outside the pharmacist's scope of practice that are not delegated by a physician through a CPA (collaborative practice agreement)
- Services provided under an invalid CPA (for example, when the effective dates have expired)

Topic #17958

Noncovered Testing for Drugs of Abuse Services

ForwardHealth does not cover:

- Any drug test performed without a specific order. Routine, nonspecific, wholesale, standing, or blanket orders for drug tests are not covered.
- Drug testing solely for legal purposes (for example, court-ordered drug screening) or for employment purposes (for example, as a pre-requisite for employment or as a requirement for continuation of employment).
- Reflex testing. Reflex tests are definitive drug tests that are performed automatically by a laboratory following a presumptive drug test; they are not based on a specific order.
- Definitive drug tests when a presumptive drug test result (positive or negative) is consistent with a member's self-report, presentation, medical history, and current prescriptions and when definitive drug testing is not necessary to further guide treatment.
- Presumptive drug tests when a direct-to-definitive drug test is performed.

In all cases, providers should only test for drugs or drug classes likely to be present based on the member's medical history, current clinical presentation, and illicit drugs that are in common use. In other words, it is **not** medically necessary or reasonable to routinely test for substances (licit or illicit) that are not used in a member's treatment population or, in the instance of illicit drugs, in the community at large.

Services Not Separately Reimbursable

Separate reimbursement is not available for these circumstances:

- Testing of two different specimen types from the same member on the same DOS (date of service), regardless of the number of providers performing the tests
- More than one presumptive or definitive drug test performed per member per DOS, regardless of the number of providers performing the tests

Obstetric Care

Topic #1260

An Overview

ForwardHealth offers providers choices of how and when to file claims for obstetric care. Providers may choose to submit claims using one of the following:

- Separate obstetric component procedure codes as they are performed
- An appropriate global obstetric procedure code with the date of delivery as the DOS (date of service)

Wisconsin Medicaid will not reimburse individual antepartum care, delivery, or postpartum care codes if a provider also submits a claim for global obstetric care codes for the same member during the same pregnancy or delivery. The exception to this rule is in the case of multiple births where more than one delivery procedure code may be reimbursed.

Topic #7757

Cesarean Sections

Nationally, the number of scheduled, elective cesarean sections has increased steadily. To ensure that the Wisconsin DHS (Department of Health Services) is reimbursing providers for performing cesarean sections only in instances where such action is medically indicated, DHS is reimbursing providers for elective cesarean sections at the same rate as for a vaginal delivery. Reimbursement rates for non-elective cesarean sections are not affected by this policy.

Elective Cesarean Sections

The reimbursement rate for elective cesarean sections is the same as for vaginal deliveries for the following procedure codes:

- 59510 (Routine obstetric care including antepartum care, cesarean delivery, and postpartum care)
- 59514 (Cesarean delivery only)
- 59515 (Cesarean delivery only; including postpartum care)

Refer to the maximum allowable fee schedule for current reimbursement rates.

Non-elective Cesarean Sections

Providers are required to use the modifier U1 (non-elective cesarean section) with the three procedure codes listed above for non-elective cesarean sections. The following are examples of non-elective cesarean sections, when the use of the U1 modifier is appropriate:

- The mother has already had a cesarean section in a previous pregnancy.
- The mother has a serious medical condition that requires emergency treatment.
- The mother has an infection that may be transmitted to the baby, such as herpes or HIV (Human Immunodeficiency Virus).
- The mother is delivering twins, triplets, or more.
- The baby is in a breech or transverse position.
- The baby is showing signs of severe fetal distress requiring immediate delivery.

Non-elective cesarean sections will receive current reimbursement rates when billed with the U1 modifier.

Cesarean Section Procedure Codes That Do Not Require a Modifier

The following cesarean procedure codes do not require a modifier and will receive current reimbursement rates:

- 59618 (Routine obstetric care including antepartum care, vaginal delivery [with or without episiotomy, and/or forceps] and postpartum care, after previous cesarean delivery)
- 59620 (Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery)
- 59622 (Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care)

Topic #1257

Complications of Pregnancy

Complications of pregnancy or delivery, such as excessive bleeding, pregnancy-induced hypertension, toxemia, hyperemesis, premature (not-artificial) rupture of membranes, and other complications during the postpartum period may all be reported and reimbursed separately from obstetrical care. The nature of these complications should be fully documented in the member's medical record.

Topic #1254

Global Obstetric Care

Providers may submit claims using global obstetric codes. Providers choosing to submit claims for global obstetric care are required to perform all of the following:

- A minimum of six antepartum visits.
- Vaginal or cesarean delivery.
- The post-delivery hospital visit and a minimum of one postpartum office visit.

When submitting claims for total obstetric care, providers should use the single most appropriate CPT (Current Procedural Terminology) obstetric procedure code and a single charge for the service. Use the date of delivery as the DOS (date of service).

All services must be performed to receive reimbursement for global obstetric care. Providers are required to provide all six (or more) antepartum visits, delivery, and the postpartum office visit in order to receive reimbursement for global obstetric care. If fewer than six antepartum visits have been performed, the provider performing the delivery may submit a claim using the appropriate delivery procedure code and, as appropriate, antepartum and postpartum visit procedure codes.

If the required postpartum office visit does not occur following claims submission for the global delivery, the provider is required to adjust the claim to reflect antepartum care and delivery if there is no documentation of a postpartum visit in the member's medical record.

Group Claims Submission for Global Obstetric Care

When several obstetric providers in the same clinic or medical/surgical group practice perform the delivery and provide antepartum and postpartum care to the same member during the pregnancy, the clinic may choose to submit a claim using a single procedure code for the service. The provider should indicate the group billing number and identify the primary obstetric provider as the rendering provider in this situation.

Topic #1253

Health Professional Shortage Area-Enhanced Reimbursement

Many obstetric procedure codes are eligible for the HPSA (Health Professional Shortage Area)-enhanced reimbursement.

Topic #1255

Member Enrollment

Services Provided Before the Member Was Enrolled in BadgerCare Plus

Obstetric payments apply only to services provided while the person is eligible as a member. Services provided prior to BadgerCare Plus enrollment are not included in the number of antepartum visits, the delivery, or postpartum care.

Fee-for-Service Member Subsequently Enrolled in a BadgerCare Plus or Medicaid HMO or SSI HMO

Wisconsin Medicaid will reimburse the equivalent of one global obstetric fee per member, per delivery, per single provider or provider group, whether the provider receives the reimbursement through BadgerCare Plus fee-for-service or through a BadgerCare Plus or Medicaid HMO or SSI (Supplemental Security Income) HMO.

A member who is initially eligible for BadgerCare Plus fee-for-service may enroll in a Medicaid HMO during her pregnancy and receive care from the same provider or clinic. In this case, the provider may be paid a global fee by the HMO after the provider receives fee-for-service payment for the antepartum care. If this is the case, the provider is required to submit an adjustment request to have the fee-for-service payment recouped.

If the provider does not submit an adjustment request in this situation, Wisconsin Medicaid will recoup the fee-for-service payment(s) through audit. If the member receives less than global obstetric care while enrolled in the BadgerCare Plus or Medicaid HMO, Wisconsin Medicaid reimburses her provider no more than the global maximum allowable fee or the sum of the individual components for services. Wisconsin Medicaid will, on audit, recoup any amount paid under fee-for-service that is more than the global fee or the combined maximum allowable fee for the services if billed separately.

Topic #2615

Newborn Reporting

Obstetric care providers are required to report babies born to BadgerCare Plus members by following the newborn reporting procedures.

Topic #1270

Newborn Screenings

All providers are required to offer to test newborns for certain congenital and metabolic disorders, per Wis. Stat. § 253.13. These

tests require a prepaid filter paper card purchased from the State Laboratory of Hygiene. Wisconsin Medicaid reimburses providers for purchasing the prepaid filter paper cards for newborn screenings performed outside a hospital setting. Medicaid reimbursement for the filter paper cards includes the laboratory handling fee. Reimbursement is limited to one prepaid filter paper card per newborn. When a baby is delivered in the home or birthing center, providers are required to use HCPCS (Healthcare Common Procedure Coding System) code S3620 (Newborn metabolic screening panel, includes test kit, postage and the laboratory tests specified by the state for inclusion in this panel [for example, galactose; hemoglobin, electrophoresis; hydroxyprogesterone, 17-D; PKU (phenylalanine); and thyroxine, total]) to report the screening panel service.

Newborn Hearing Screening

Evoked otoacoustic emissions hearing screens for newborns are included in the E&M (evaluation and management) of the newborn and are not separately reimbursable. Wisconsin Medicaid separately reimburses CPT (Current Procedural Terminology) code 92650 (Auditory evoked potentials; screening of auditory potential with broadband stimuli; automated analysis) following a newborn's failed hearing screening, if medically necessary.

Critical Congenital Heart Disease Screening

Screening for critical congenital heart disease by pulse oximetry is included in the initial E&M of the newborn and is not separately reimbursable.

Topic #1250

Separately Reimbursable Pregnancy-Related Services

Services that may be reimbursed separately from the global or component obstetrical services may include:

- Administration of Rh immune globulin.
- Amniocentesis, chorionic villous sampling, and cordocentesis.
- Epidural anesthesia.
- External cephalic version.
- Fetal biophysical profiles.
- Fetal blood scalp sampling.
- Fetal contraction stress and non-stress tests.
- Harvesting and storage of cord blood.
- Insertion of cervical dilator.
- Laboratory tests, excluding dipstick urinalysis.
- Obstetrical ultrasound and fetal echocardiography.
- Sterilization.
- Surgical complications of pregnancy (for example, incompetent cervix, hernia repair, ovarian cyst, Bartholin cyst, ruptured uterus, or appendicitis).

Topic #1248

Unrelated Conditions

Any E&M (evaluation and management) services performed that are related to the pregnancy are included in reimbursement for obstetrical care. However, conditions unrelated to the pregnancy may be separately reimbursed by Wisconsin Medicaid, including:

- Chronic hypertension.

- Diabetes.
- Management of cardiac, neurological, or pulmonary problems.
- Other conditions (for example, urinary tract infections) with a diagnosis other than complication of pregnancy.

Topic #1247

Unusual Pregnancies

Providers treating members whose pregnancies require more than the typical number of antepartum or postpartum visits or result in complications during delivery may seek additional reimbursement by submitting an Adjustment/Reconsideration Request (F-13046 (02/2025)) form for the allowed claim. A copy of the medical record and/or delivery report specifying the medical reasons for the extraordinary number of antepartum or postpartum visits must be attached to the claim. Wisconsin Medicaid will review the materials and determine the appropriate level of reimbursement.

Screening, Brief Intervention, and Referral to Treatment Benefit

Topic #8297

An Overview

Definition

The SBIRT (Screening, Brief Intervention, and Referral to Treatment) benefit is covered for members enrolled in BadgerCare Plus and Wisconsin Medicaid. Members enrolled in an HMO must receive the services through the HMO. This benefit applies to members who are 10 years of age or older on the DOS (date of service). These services do not require PA (prior authorization) and are not subject to copay.

The purpose of the SBIRT benefit is to identify and assist members at risk for substance abuse problems. The benefit has two components:

- Screening for substance abuse problems
- Brief preventive substance abuse intervention for members identified as being at risk for having substance abuse disorders

The substance abuse screening and intervention services are designed to prevent members from developing a substance abuse disorder. These services are not intended to address tobacco abuse. These services are not intended to treat members diagnosed with a substance abuse disorder or to treat members already receiving substance abuse treatment services. Members identified through the screening and intervention process as needing more extensive or specialized treatment should be referred to an appropriate substance abuse program. A physician's prescription is not required for SBIRT services.

To be reimbursable, SBIRT services must be provided on a face-to-face basis (either in person or via simultaneous audio and video transmission).Phone and internet-based communications with members are not covered.

Members who are pregnant are eligible for substance abuse screening and intervention services through a separate benefit designed specifically for pregnant women. ForwardHealth will not cover both benefits during the member's pregnancy. Providers are required to use either the benefit for pregnant women or the SBIRT benefit for the substance abuse screening and intervention services.

Substance Abuse Screening

Substance abuse screening is a method for identifying people who use alcohol or drugs in a way that puts them at risk for problems or injuries related to their substance use. Wisconsin Medicaid and BadgerCare Plus cover substance abuse screening in a wide variety of settings to increase the chance of identifying people at risk. Screening is also a part of primary prevention aimed at educating members about the health effects of using alcohol and other drugs.

Providers are required to use an evidence-based screening tool to identify members at risk for substance abuse problems. A few brief questions on substance use may be asked to identify those individuals likely to need a more in-depth screening. Those brief screening questions, however, do not meet the criteria for reimbursement for this benefit. The screening tool must demonstrate sufficient evidence that it is valid and reliable to identify individuals at risk for a substance abuse disorder and provide enough information to tailor an appropriate intervention to the identified level of substance use. The areas that must be covered include:

- The quantity and frequency of substance use
- Problems related to substance use
- Dependence symptoms

- Injection drug use

The screening tool should be simple enough to be administered by a wide range of health care professionals. It should also focus on the frequency and the quantity of substance use over a particular time frame (generally 1 to 12 months).

Below is a listing of evidence-based substance abuse screening tools that meet the criteria for reimbursement for this benefit. Providers may choose tools that are not included on the list as long as they meet the criteria above. In addition, providers must obtain prior approval from the Wisconsin DHS (Department of Health Services) before using a tool that is not listed below. Contact DHS at **DHSSBIRT@wisconsin.gov** for additional information. The approved tools include the following:

- The AUDIT (Alcohol Use Disorders Inventory Test). This screen is a reliable tool for use to determine the level of alcohol use. The AUDIT screen is available through the WHO (World Health Organization) Web site.
- The DAST (Drug Abuse Screening Test). This screening tool is a reliable tool to use to determine the level of drug use. The DAST screen is available through the Dr. Alan Tepp, Ph. D., website.
- The ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test). This screen is available through the WHO website.
- The CRAFFT screening tool developed by John Knight at the CeASAR (Center for Adolescent Substance Abuse Research). The CRAFFT screening tool is available through the CeASAR website. This screen is valid for use with children and adolescents.
- The POSIT (Problem Oriented Screening Instrument for Teenagers). This screen is valid for use in adolescents in a medical setting. A POSIT PC tool is available through the POSIT PC website.

Providers may use more than one screening tool during the screening process when appropriate; however, there is no additional reimbursement for using more than one screening tool.

Substance Abuse Intervention

Brief substance abuse intervention services are covered for members who are identified through the use of an evidence-based screening tool as being at risk for substance abuse disorder(s). The purpose of the intervention is to motivate the member to decrease or abstain from alcohol consumption and/or drug use. Brief intervention may be a single session or multiple sessions using a motivational discussion that focuses on increasing insight and awareness regarding substance use and increasing motivation toward behavioral change. Brief intervention can also be used for those in need of more extensive levels of care, as a method of increasing motivation and acceptance of a referral to specialty substance abuse treatment.

Wisconsin Medicaid and BadgerCare Plus cover brief intervention services provided during the same visit as the screening or during a separate visit. The brief intervention is not covered for members who have not had a substance abuse screen.

Providers are required to use effective strategies for the counseling and intervention services although BadgerCare Plus and Wisconsin Medicaid are not endorsing a specific approach.

Examples of effective strategies for the intervention services include the following:

- The SBIRT protocols. The SBIRT protocols are available through the U.S. Department of Health and Human Services.
- "Helping Patients Who Drink Too Much," A Clinician's Guide, Updated 2005 Edition, available through the U.S. Department of Health and Human Services.

Topic #8337

Coverage Limitations

Substance Abuse Screening

For members enrolled in BadgerCare Plus or Wisconsin Medicaid, the screening is limited to one unit of service per rolling 12 months. A unit of service is equivalent to the total amount of time required to administer the screening.

The screening is not considered part of the mental health and substance abuse services available under ForwardHealth. The screening is not counted towards any service limitations or PA (prior authorization) thresholds for those services.

Substance Abuse Intervention

For members enrolled in BadgerCare Plus and Wisconsin Medicaid, the intervention services are limited to four hours per rolling 12 months. A unit of service is 15 minutes, so the four-hour limit is equal to 16 units of service.

Only one hour (up to four units of service) can be billed on one DOS (date of service). The intervention services may be provided on the same DOS or on a later DOS than the screening.

The intervention services are not considered part of the mental health and substance abuse services available under ForwardHealth and are not counted towards any service limitations or PA thresholds for those services.

Topic #8338

Documentation Requirements

In addition to documenting the service provided, providers are required to keep a copy of the completed screening tool(s) in the member's medical record. Providers using electronic medical records should make a note of which screening tool was used if they do not have an electronic version of the tool, and note the member's responses to the screening questions. Providers are also required to retain documents concerning the provider's education, training, and supervision.

Refer to the Documentation chapter of the Provider Enrollment and Ongoing Responsibilities section of the appropriate Online Handbook for more information about additional documentation requirements.

Topic #8317

Eligible Providers

Early detection of substance abuse problems is crucial to successfully treating members. It is also important for members to obtain referrals for follow-up care when appropriate. In order to accomplish these goals, BadgerCare Plus and Wisconsin Medicaid are allowing a wide range of Medicaid-enrolled providers to administer the SBIRT (Screening, Brief Intervention, and Referral to Treatment) services.

The following table lists providers eligible to receive reimbursement for the screening and the substance abuse intervention services.

Provider Type	Eligible for Reimbursement of Services Provided Under the SBIRT benefit?
Advanced practice nurse prescribers with psychiatric specialty	Allowed
Crisis intervention providers	Allowed
HealthCheck providers	Allowed
Master's-level psychotherapists in outpatient mental health	Allowed when provided in conjunction with a primary care, hospital,

or substance abuse clinics	and/or emergency room visit
Nurse practitioners	Allowed
Pharmacists	Allowed
Physicians	Allowed
Physicians assistants	Allowed
Prenatal care coordination providers	Allowed
Psychiatrists	Allowed
Psychologists in outpatient mental health or substance abuse clinics	Allowed when provided in conjunction with a primary care, hospital, and/or emergency room visit
Substance abuse counselors in outpatient mental health or substance abuse clinics	Allowed when provided in conjunction with a primary care, hospital, and/or emergency room visit

Providers are required to retain documents showing that staff providing substance abuse screening and intervention services meet the training, education, and supervision requirements.

Requirements for Licensed Individuals

Licensed health care professionals must complete the Wisconsin DHS (Department of Health Services)-approved training to directly deliver the screening and intervention services. Training for licensed professionals must extend at least 4 hours and may be conducted in person or via the internet. DHS may exempt licensed professionals with expertise in the field of substance abuse screening and motivational enhancement or motivational interviewing on a case by case basis.

Providers should contact DHS at **DHSSBIRT@wisconsin.gov** for more information about the required training or to find out if they can be exempted from the training requirements.

Requirements for Unlicensed Individuals

Unlicensed individuals may provide screening or brief intervention services if they meet all of the following criteria:

- Successfully complete at least 60 hours of training related to providing screening and brief intervention for alcohol and substance abuse (other than tobacco). This training includes the DHS-approved training to deliver the screening and intervention services. At least 30 hours of training must be conducted in person.
- Provide the screening and intervention services under the supervision of a licensed health care professional.
- Follow written or electronic protocols for evidence-based practice during the delivery of screening and intervention services. Protocols must be consistently followed, so the licensed health care professional must ensure that quality assurance procedures are in place for the written or electronic protocols.

Topic #8318

Procedure Codes and Diagnosis Codes

The following tables list the HCPCS (Healthcare Common Procedure Coding System) procedure codes and applicable diagnosis codes that providers are required to use when submitting claims for substance abuse screening and substance abuse intervention services under the SBIRT (Screening, Brief Intervention, and Referral to Treatment) benefit.

Place of Service Codes (Submitted on the 1500 Health Insurance Claim Form ((02/12)))

03	School
11	Office
12	Home
19	Off Campus — Outpatient Hospital
21	Inpatient Hospital
22	On Campus — Outpatient Hospital
23	Emergency Room — Hospital
27	Outreach Site/Street
99	Other Place of Service

Substance Abuse Screening and Intervention Services				
Procedure Code	**Description**	**Limitations (Medicaid and BadgerCare Plus)**	**Allowable Place of Service**	**Allowable Diagnosis Code**
H0049	Alcohol and/or drug screening	Limited to one unit per member, per rolling 12 months.	03, 11, 12, 19, 21, 22, 23, 27, 99	Z13.9 (Encounter for screening, unspecified)
H0050	Alcohol and/or drug service, brief intervention, per 15 minutes	Limited to 16 units per member, per rolling 12 months.	03, 11, 12, 19, 21, 22, 23, 27, 99	Z71.89 (Other specified counseling)

Surgery Services

Topic #557

Abortions

Coverage Policy

In accordance with Wis. Stat. § 20.927, abortions are covered when one of the following situations exists:

- The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests, based on their best clinical judgment, that the abortion meets this condition by signing a certification.
- In a case of sexual assault or incest, provided that prior to the abortion the physician attests that sexual assault or incest has occurred, to their belief, by signing a written certification; the crime must also be reported to the law enforcement authorities.
- Due to a medical condition existing prior to the abortion, provided that prior to the abortion the physician attests, based on their best clinical judgment, that the abortion meets the following condition by signing a certification that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman.

When submitting a claim to ForwardHealth, physicians are required to attach or upload via the ForwardHealth Portal a completed and signed certification statement attesting to one of the previous circumstances. The optional Abortion Certification Statements (F-01161 (09/2019)) form is available to use in this situation. Providers may develop a form of their own, as long as it includes the same information.

Covered Services

When an abortion meets the state and federal requirements for Medicaid payment, office visits and all other medically necessary related services are covered. Treatment for complications arising from an abortion are covered, regardless of whether or not the abortion itself is a covered service, because the complications represent new conditions, and thus the services are not directly related to the performance of an abortion.

Coverage of Mifeprex

Wisconsin Medicaid reimburses for Mifeprex under the same coverage policy that it reimburses other surgical or medical abortion procedures under Wis. Stat. § 20.927.

When submitting claims for Mifeprex, providers are required to:

- Use the HCPCS (Healthcare Common Procedure Coding System) code S0190 (Mifepristone, oral, 200 mg) for the first dose of Mifeprex, along with the E&M (evaluation and management) code that reflects the service provided. Do not use HCPCS code S0199; bill components (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 (ultrasounds, office visits) of services performed separately.
- For the third visit, use the E&M code that reflects the service provided.
- Include the appropriate ICD (International Classification of Diseases) abortion diagnosis code with each claim submission.
- Attach to each claim a completed abortion certification statement that includes information showing the situation is one in which the abortion is covered.

Note: ForwardHealth denies claims for Mifeprex reimbursement when billed with an NDC (National Drug Code).

Physician Counseling Visits Under Wis. Stat. § 253.10

Wis. Stat. § 253.10, provides that a woman's consent to an abortion is not considered informed consent unless at least 24 hours prior to an abortion a physician has, in person, orally provided the woman with certain information specified in the statute.

Pursuant to this statute, Wisconsin DHS (Department of Health Services) has issued preprinted material summarizing the statutory requirements and a patient consent form. Copies of these materials may be obtained by writing to the following address:

Administrator
Division of Public Health
PO Box 2659
Madison WI 53701-2659

An office visit during which a physician provides the information required by this statute is covered.

Services Incidental to a Noncovered Abortion

Services incidental to a noncovered abortion are not covered. Such services include, but are not limited to, any of the following services when directly related to the performance of a noncovered abortion:

- Anesthesia services
- Laboratory testing and interpretation
- Recovery room services
- Transportation
- Routine follow-up visits
- Ultrasound services

Topic #558

Anesthesia by Surgeon

Reimbursement for anesthesia provided by the surgeon (for example, local infiltration, digital block, topical anesthesia, regional anesthesia, and general anesthesia) is included in the Medicaid reimbursement for the surgical or diagnostic procedure(s) performed and is not separately reimbursable.

However, if the anesthesia is the primary procedure performed, for diagnosis or treatment, it is separately reimbursable. For example, if an intercostal nerve block is done for diagnosis and treatment of post-therapeutic neuralgia, and an epidural steroid injection procedure is also done, the anesthetic procedure is separately reimbursable.

Topic #559

Bariatric Surgery

Bariatric surgery, revision of bariatric surgery, and repeat bariatric surgery (CPT (Current Procedural Terminology) procedure codes 43644, 43645, 43770–43775, 43843, 43845–43848, 43886–43888) are covered under certain circumstances with PA (prior authorization).

Topic #560

Breast Reconstruction

Breast reconstruction requires PA (prior authorization); however, PA is **waived** for breast reconstruction when performed following a mastectomy for breast cancer and when the claim includes one of the following ICD (International Classification of Diseases) diagnosis codes for breast cancer or a personal history of breast cancer. (Breast reconstruction is identified by CPT (Current Procedural Terminology) codes 19316–19323, 19325, 19340–19350, 19357–19365, 19367–19369, 19370, 19371, 19380–19396.) PA is also waived for certain skin grafting codes when performed in conjunction with breast reconstruction when one of the following ICD diagnosis codes for breast cancer or a personal history of breast cancer is present. (Skin grafting is identified by CPT codes 15771-15774.)

ICD Diagnosis Code	Description
C50.011	Malignant neoplasm of nipple and areola, right female breast
C50.012	Malignant neoplasm of nipple and areola, left female breast
C50.111	Malignant neoplasm of central portion of right female breast
C50.112	Malignant neoplasm of central portion of left female breast
C50.211	Malignant neoplasm of upper-inner quadrant of right female breast
C50.212	Malignant neoplasm of upper-inner quadrant of left female breast
C50.311	Malignant neoplasm of lower-inner quadrant of right female breast
C50.312	Malignant neoplasm of lower-inner quadrant of left female breast
C50.411	Malignant neoplasm of upper-outer quadrant of right female breast
C50.412	Malignant neoplasm of upper-outer quadrant of left female breast
C50.511	Malignant neoplasm of lower-outer quadrant of right female breast
C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
C50.611	Malignant neoplasm of axillary tail of right female breast
C50.612	Malignant neoplasm of axillary tail of left female breast
C50.811	Malignant neoplasm of overlapping sites of right female breast
C50.812	Malignant neoplasm of overlapping sites of left female breast
Z85.3	Personal history of malignant neoplasm of breast

Topic #572

Cataract Surgery

When a surgeon performs all of the components of cataract surgery, including preoperative, surgical, and postoperative care, the appropriate surgical procedure code should be indicated on the claim. Providers should follow the guidelines outlined here if another physician or an optometrist performs postoperative care.

Surgical Care Only

Submitting claims for surgical care only is allowed when one surgeon performs the cataract surgery and another provider delivers postoperative management. Surgical care only is identified by adding modifier 54 (Surgical care only) to the appropriate

procedure code on the claim. Use of modifier 54 is allowed only for cataract surgery procedure codes 66820-66988 for preoperative care and surgery when post-operative care is performed by an optometrist. Wisconsin Medicaid does not separately reimburse surgical care (modifier 54) for any other surgical procedure codes.

The following criteria apply when using modifier 54:

- The modifier is allowable only for the surgeon who performed the surgery.
- The surgeon is reimbursed at 80 percent of the global maximum allowable fee for performing the surgery.
- Wisconsin Medicaid will not reimburse more than what the global period allows for a given surgery. The sum of reimbursement for separately performed "surgical care only" and "postoperative management only" will not exceed the global maximum allowable fee for cataract surgery, regardless of the number of providers involved. Reimbursement may be reconciled in post-pay audit.
- Hospital inpatients: If cataract surgery is performed on a hospital inpatient, only the surgeon may submit claims for the appropriate cataract procedure codes with modifier 54. Any other provider who sees the member during the inpatient stay will be reimbursed only for medically necessary E&M (evaluation and management) procedures (for example, 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 66820-66988 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% of the global maximum allowable fee for providing postoperative management for major surgery.
- When two or more provider types (ophthalmologists, optometrists, or other qualified providers) split postoperative management, reimbursement will be reduced proportionately following post-pay review of the claims and/or medical records.
- The surgeon **and** all postoperative management providers are required to keep a copy of the written transfer agreement with the dates of relinquishment and assumption of care in their member's medical record.
- The dates that the postoperative management was provided as indicated on the claim must occur on and after those indicated on the transfer agreement. A claim with a DOS (date of service) prior to what was indicated on the transfer agreement will be denied during post-pay review and the reimbursement will be recouped.
- Wisconsin Medicaid does not require providers to submit additional supporting clinical documentation as part of the claims submission process for cataract surgery.

Preoperative Management

Preoperative management is included in the reimbursement rate for surgical care and is not separately reimbursable. Wisconsin

Medicaid does not separately reimburse modifier 56 (Preoperative management only) when submitting claims for preoperative management.

Topic #578

Co-surgeons/Assistant Surgeons

Assistant Surgeons

When two or more surgeons perform one or more procedures that are generally performed by a surgeon and an assistant (or assistants), the principal surgeon submits a claim for the surgery procedure code(s) and the additional surgeon(s) submits a claim for the surgery procedure code(s) with the appropriate modifier.

Following are CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) definitions of the accepted assistant surgeon modifiers:

- 80 — Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number (s).
- 81 — Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.
- 82 — Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).
- AS — Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery.

Reimbursement for Assistant Surgeon Services

ForwardHealth reimburses surgical assistance services at 20% 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.

Co-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) with the co-surgeon modifier listed below. Additional supporting clinical documentation (such as an operative report) clearly marked "co-surgeon" must be submitted with each surgeon's claim to demonstrate medical necessity and to identify the co-surgeons.

Following are CPT and HCPCS definitions of the accepted co-surgeon modifier:

- 62 — Two Surgeons: When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should bill his/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 procedure(s) (including add-on procedures [s]) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or 82 added, as appropriate.

Reimbursement for Co-surgeon Services

ForwardHealth reimburses each co-surgeon at 100% of ForwardHealth's usual surgeon rate for the specific procedure they have performed.

Topic #575

Contraceptive Implants

Contraceptive implant services and devices are covered. Providers should indicate the appropriate procedure code for the insertion or removal of the contraceptive implant and the appropriate procedure code for the implant device. Providers should not submit claims for E&M (evaluation and management) services associated with contraceptive implant services, unless another separate and distinct service is provided and documented in the member's medical record.

Informed Consent Procedure

ForwardHealth recommends that providers of implantable contraceptives have a fully informed consent procedure and present comprehensive information to members prior to the implantation procedure. This information should include the following:

- Physiological effects of contraceptive implants
- Risks associated with implant use
- Potential side effects
- Recommendations for follow-up care and removal

As part of the informed consent process, ForwardHealth recommends using information provided in the patient education materials supplied by the manufacturer. Members should be informed of the following considerations:

- Some patients may experience thick, permanent scarring of the skin at the insertion and removal site (keloid formation).
- Migration of the device may occur, making removal difficult.
- Members can request the implant be removed at any time.
- The implant does not provide protection against STDs (sexually transmitted diseases).

ForwardHealth recommends that informed consent be documented in the member's medical record and include the signatures or initials of both the provider and the member.

ForwardHealth recommends providing a waiting period between the education session and the insertion of the implant, as it may help ensure that a proper amount of time is allowed for an informed decision. Some providers indicate that this allows increased member acceptance of the implant. Such a waiting period may not always be acceptable, however, considering factors such as member preferences and limited transportation.

Topic #22677

Coverage Policy for Miscarriage Management

This topic addresses miscarriage management for the spontaneous loss of an intrauterine pregnancy.

Covered Services

ForwardHealth covers surgical and medical treatments for miscarriage management for the spontaneous loss of an intrauterine pregnancy.

Providers should follow CPT (Current Procedural Terminology) and ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) coding guidance to appropriately report procedure and diagnosis codes related to surgical or medical treatment on the applicable claim form.

Surgical Management

Surgical intervention is covered when clinically appropriate.

Medical Management

Medical management may include either the use of both mifepristone and misoprostol or misoprostol alone. Providers are required to document a clinical assessment prior to the administration of these drugs.

Claim Requirements for Mifepristone and Misoprostol

When submitting claims for mifepristone and/or misoprostol, providers are required to:

- Use HCPCS (Healthcare Common Procedure Coding System) code S0190 (Mifepristone, oral, 200mg) for the first dose of mifepristone, along with the E&M (evaluation and management) code that reflects the service provided. Note: ForwardHealth denies claims when billed with a NDC (National Drug Code).
- Use HCPCS code S0191 (Misoprostol, oral, 200mcg) for the drug given during the first or subsequent visits, along with the E&M code that reflects the service provided.

Modifier U9 (procedure code documented on the claim when delivery is at full term) should be used when billing HCPCS codes S0190 and S0191 to indicate drug(s) administered for miscarriage management.

ForwardHealth does not cover HCPCS code S0199 (Medically induced abortion by oral ingestion of medication including all associated services and supplies [for example, patient counseling, office visits, confirmation of pregnancy by HCG, ultrasound to confirm the duration of pregnancy, ultrasound to confirm completion of abortion] except drugs). Providers must bill components (for example, ultrasounds and office visits) of services performed separately.

Topic #579

Dilation and Curettage

Providers are required to submit a paper claim for dilation and curettage. The claim must include additional supporting clinical documentation such as a preoperative history or physical exam report.

Topic #15577

Dorsal Column or Spinal Stimulator Implant Surgeries

Implantation of dorsal column (spinal cord) stimulators has been shown to provide benefit when treating chronic intractable pain in situations such as failed back surgery and complex pain syndromes. Because the procedure is invasive and has a significant complication rate, it should only be considered for conditions where evidence supports its efficacy and when more conservative methods have failed.

Dorsal column stimulator trials and surgeries require PA (prior authorization). Dorsal column stimulator trials and surgeries that do not meet the PA approval criteria are considered noncovered. Any charges related to the noncovered dorsal column stimulator

surgeries will not be reimbursed.

A surgeon may receive separate reimbursement for the device if the surgery is performed in an outpatient hospital or ambulatory surgery center and the surgeon is Medicaid-enrolled as a DME (durable medical equipment) provider.

Topic #580

Foot Care

Wisconsin Medicaid covers the cleaning, trimming, and cutting of toenails once every 31 days (for one or both feet) if the member has one of the following systemic conditions:

- Arteriosclerosis obliterans evidenced by claudication
- Cerebral palsy
- Diabetes mellitus
- Peripheral neuropathies involving the feet, which are associated with one of the following:
  - Malnutrition or vitamin deficiency
  - Carcinoma
  - Diabetes mellitus
  - Drugs and toxins
  - Multiple sclerosis
  - Uremia

Unna Boots

The application of unna boots is reimbursable for members with one of the following diagnoses:

- Varicose veins of lower extremities
- Venous insufficiency, unspecified
- Chronic ulcer of skin
- Decubitus or other ulcer of lower extremity
- Edema of lower extremities

Reimbursement for the cost of the unna boot is included in the reimbursement for the application procedure.

Topic #21317

Gender-Affirming Medical and Surgical Treatment

In response to the permanent injunction in Flack vs. Wisconsin Department of Health Services, 18-cv-309-wmc, by the United States District Court for the Western District of Wisconsin signed October 31, 2019, ForwardHealth no longer prohibits coverage of gender-affirming care based on Wisconsin Administrative Code's permanently enjoined exclusion of: "Drugs, including hormone therapy, associated with transsexual surgery or medically unnecessary alteration of sexual anatomy or characteristics" and "Transsexual surgery." To provide appropriate health care per Wis. Stat. § 49.45(1) and consistent with the permanent injunction, ForwardHealth has updated the gender-affirming care that is currently allowable under ForwardHealth.

Gender-affirming care, as defined by the World Health Organization, encompasses a range of social, psychological, behavioral, and medical interventions designed to support and affirm an individual's gender identity when it conflicts with the gender they were assigned at birth. As noted by the American Psychiatric Association, identity includes individuals along a continuum.

The American Medical Association and other specialty medical societies recommend gender-affirming care as medically

necessary for improving the physical and mental health of TGD (transgender and gender diverse) people, while outlining this care through evidence-based clinical guidelines.

ForwardHealth covers GAMASTs (gender-affirming medical and/or surgical treatments) for individuals who may identify as, but are not limited to, the following:

- Male
- Female
- Gender diverse
- Nonbinary
- Agender
- Intersex
- Eunuch

ForwardHealth covers GAMASTs with an approved PA (prior authorization) request. Refer to the Pharmacy Resources page for further details regarding PA coverage criteria for gender-affirming hormone therapy. ForwardHealth reviews PA requests for GAMASTs on a case-by-case basis in accordance with federal regulations, including those found in Section 1557 of the Affordable Care Act and in accordance with medical necessity as defined in Wis. Admin. Code § DHS 101.03(96m) and best practices.

Surgical Coverage Criteria

ForwardHealth has established the following coverage criteria for gender-affirming surgical procedures requested and covered under Wis. Admin. Code §§ DHS 107.06(1) and 107.06(2)(c):

- The member has a gender incongruence-related diagnosis and referral for the requested surgical and/or medical procedure from at least one HCP (health care professional) who has expertise and experience and who is qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity:
  - ForwardHealth will accept a gender incongruence diagnosis from the following professionals who are qualified and licensed by their statutory body and hold, at a minimum, a Master's degree in a clinical field relevant to the role of assessing and diagnosing TGD individuals:
    - Mental health professional who holds a Master's degree or higher
    - Medical practitioners (for example, Doctor of Medicine, [M.D.], Doctor of Osteopathic Medicine [D.O.], physician assistant [P.A.]) with authority to diagnose
    - Nurse practitioner
    - Other qualified health professional who holds a Master's degree or higher
- The member has a diagnosis as referenced and coded in the currently utilized ICD-10 (International Classification of Diseases, 10th Revision):
  - F64.0 (Transexualism)
  - F64.1 (Dual role transvestism)
  - F64.2 (Gender identity disorder of childhood)
  - F64.8 (Other gender identity disorder)
  - F64.9 (Gender identity disorder, unspecified)
  - F66 (Other sexual disorders)
  - Z41.8 (Encounter for other procedures for purposes other than remedying health state)
  - Z41.9 (Encounter for procedure for purposes other than remedying health state, unspecified)
  - Z87.890 (Personal history of sex reassignment)
- Surgeons who make surgical requests must maintain an active practice in gender-affirming surgical procedures.
- Documentation must include all of the following:
  - Informed consent has been properly obtained.
  - The member understands and can participate in the treatment plan.
  - The provider/team has discussed the effect of gender-affirming surgical intervention(s) on reproduction.

    - The after-care plan for surgical care.
- Although co-morbidities may exist, the member's gender incongruence or dysphoria regarding body parts or bodily function is not a result of any other physical and/or mental health condition and other possible causes of gender incongruence have been excluded:
    - Any physical and mental health conditions that could negatively impact the outcome of GAMASTs are assessed, with risks and benefits discussed, before a decision is made regarding treatment (for example, the TGD person is unable to engage with the process of transition or would be unable to manage aftercare following surgery, even with support).
- Gender-affirming hormonal treatment is required for gonadectomy and genital surgeries to achieve the desired surgical result (s). The member must be stable on their treatment regime for at least six months:
    - Providers must document in the member's medical record if hormone treatment is either not desired or is medically contraindicated for gonadectomy and genital procedures.
    - Hormone treatment is not a requirement for other surgical procedures.
- The member and the provider have identified which treatments or combinations of treatments are appropriate for that member's individual needs and should consider the individual's risks prior to treatment (for example, breast cancer prior to breast augmentation or mastectomy).

Covered Surgical Procedures Considered

ForwardHealth will consider coverage for surgical and medical services and procedures as summarized in WPATH (World Professional Association for Transgender Health) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, except for services listed in Wis. Admin. Code § DHS 107.06(5).

Covered services include, but are not limited to, the following categories:

Assigned Male at Birth (AMAB):

- Facial feminization surgery
- Voice feminization surgeries (for example, anterior glottal web formation, cricothyroid approximation, laser reduction glottoplasty)
- Gender-affirming breast surgery
- Gender-affirming genital surgeries including orchiectomy, vagino/vulvoplasty (with/without depth), penectomy, and labioplasty
- Body contouring procedures
- Procedures designed to prepare individuals for surgery (for example, hair removal)

Assigned Female at Birth (AFAB):

- Facial masculinization surgery
- Gender-affirming chest surgery
    - If the member is 40 years of age or older, they have had a negative (for cancer) mammogram that was performed within the year prior to the date of a planned reduction mammoplasty.
- Gender-affirming genital surgeries including hysterectomy/oophorectomy, vaginectomy, metoidioplasty (including placement of testicular prostheses), scrotoplasty, phalloplasty (including placement of testicular/penile prostheses)
- Body contouring procedures
- Procedures designed to prepare individuals for surgery (for example, hair removal)

Additional Coverage Criteria for Members Under 18 Years of Age

ForwardHealth has established additional coverage criteria for members under 18 years of age, which must be documented in the PA request:

- The member's psychological, family, and social issues have been extensively explored by a care team consisting of

providers experienced in adolescent behavioral health and gender identity, and these issues have been actively considered regarding the treatment recommendation.
- Recommended irreversible physical interventions must be addressed in the context of adolescent development.
- The adolescent's shift toward gender conformity is not occurring primarily to please the parent or guardian, nor for any other social reinforcement. Procedures must be documented and supported by long-term gender identification.
- For irreversible, surgical interventions, documentation must be submitted that the member has actively participated in a staged process through fully reversible and partially reversible interventions, as indicated by WPATH. Adequate time must have passed for the member and their parent or guardian to assimilate the member's gender identity and receive adequate support as a family.

Postoperative Complications

Procedures to remedy postoperative complications of gender-affirming surgery (for example, stenosis, scarring, chronic infection, or pain) are not considered a separate gender-affirming surgery.

Additional Considerations

Providers are advised of the following:

- ForwardHealth will cover permanent hair removal procedures, except as identified in the Wis. Admin. Code § DHS 107.06(5) for noncovered services, as preoperative protocols for gender affirming surgery when medically necessary.
- Reversal of prior gender-affirming surgery is considered a separate gender-affirming surgery. Coverage and PA approval criteria for gender-affirming surgery apply.

Medical Services with Current Established Policies

Hormone replacement therapy is a covered service as described in Section 1557 of the Affordable Care Act, in accordance with medical necessity as defined in Wis. Admin. Code § DHS 101.03(96m), and best practices. For pharmacy coverage, providers may refer to the Pharmacy service area of the Online Handbook and the Pharmacy Resources page of the Portal.

Voice therapy is a covered service under Wis. Admin. Code § DHS 107.18 and may be considered for members with a gender incongruence-related diagnosis. A PA request must be submitted for voice therapy services when the primary purpose is to provide treatment for gender voice incongruence as prescribed by a physician. Voice therapy must be provided by a certified speech-language pathologist or under the direct, immediate on-premises supervision of a certified speech-language pathologist.

Topic #12397

Gynecomastia Surgery

ForwardHealth covers mastectomy for gynecomastia when medically necessary per Wis. Admin. Code § DHS 101.03(96m); however, PA (prior authorization) is required for coverage of gynecomastia surgery.

Providers are required to include CPT (Current Procedural Terminology) procedure code 19300 (Mastectomy for gynecomastia) when submitting PA requests or claims for gynecomastia surgery. Allowable ICD (International Classification of Diseases) diagnosis codes include the following:

- N62 (Hypertrophy of breast)
- N64.4 (Mastodynia)
- Q98.0–Q98.9 (Other sex chromosome abnormalities, male phenotype, not elsewhere classified)

Topic #581

Hysterectomies

An Acknowledgment of Receipt of Hysterectomy Information (F-01160 (06/2013)) form must be completed prior to a covered non-emergency hysterectomy, except in the following circumstances:

- The member was already sterile. Sterility may include menopause. (The physician is required to state the cause of sterility in the member's medical record.)
- The hysterectomy was required as the result of a life-threatening emergency situation in which the physician determined that a prior acknowledgment of receipt of hysterectomy information was not possible. (The physician is required to describe the nature of the emergency.)
- The hysterectomy was performed during a period of retroactive member eligibility and one of the following circumstances applied:
  - The member was informed before the surgery that the procedure would make her permanently incapable of reproducing.
  - The member was already sterile.
  - The member was in a life-threatening emergency situation that required a hysterectomy.

If any of the above circumstances apply, providers are required to include signed and dated documentation (for example, a copy of the preoperative history or physical exam or the operative report for a surgical procedure) with the claim.

Providers may upload the Acknowledgment of Receipt of Hysterectomy Information form via the Portal for electronically submitted claims or attach it to a paper 1500 Health Insurance Claim Form ((02/12)) or UB-04 Claim Form.

Noncovered Services

ForwardHealth does not cover a hysterectomy for uncomplicated fibroids, a fallen uterus, or a retroverted uterus.

ForwardHealth does not cover hysterectomies for the purpose of sterilization. The Acknowledgment of Receipt of Hysterectomy Information form is not to be used for purpose of consent of sterilization.

Topic #20718

Implantation of Artificial Heart

ForwardHealth covers implantation of an artificial heart with an approved PA (prior authorization) request when the service is being used as a bridge to transplantation of a solid organ.

Topic #16817

Intrathecal Infusion Pumps for Spasticity or Pain

Placement of IIP (intrathecal infusion pumps) for the treatment of spasticity or pain is covered by ForwardHealth with PA (prior authorization).

Implantation of spinal cord pumps for infusion may provide benefit when treating chronic, intractable spasm and/or pain caused by diseases of, or injury to, the brain and/or spinal cord. The implantation procedure is invasive and has a significant complication rate; therefore, it should only be considered for conditions where evidence supports its effectiveness and where more conservative methods to control spasm and/or pain have failed.

Baclofen (Lioresal) is a derivative of GABA (gamma aminobutyric acid) that acts specifically at the spinal end of the upper motor neurons to cause muscle relaxation. Intrathecal baclofen may be indicated for patients with chronic, intractable spasticity.

Intrathecal medication for pain management is an alternative for cancer patients and other severe, chronic, and intractable pain sufferers whose pain is not relieved by conventional drugs or other methods of opiate delivery. It may also serve as an alternative for patients who cannot tolerate the side effects of systemic administration of opioids in the doses needed for adequate pain management. ForwardHealth covers an IIP when used to administer opioid drugs, ziconotide, and/or clonidine intrathecally or epidurally for those patients who have proven unresponsive to less invasive medical therapy.

ForwardHealth considers the implantation of an IIP for delivery of baclofen or opioid pain medication a treatment of last resort.

Intrathecal Infusion Pumps for Treatment of Spasticity Screening Dose

Intrathecal pumps for baclofen for the treatment of spasticity require that a screening dose be administered prior to implantation surgery. Providers are required to use one of the following CPT (Current Procedural Terminology) procedure codes, along with modifier U5, to designate the baclofen screening dose:

- 62320 **with modifier U5** (Injection[s], of diagnostic or therapeutic substance[s] [for example, anesthetic, antispasmodic, opioid, steroid, other solution], not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance).
- 62321 **with modifier U5** (Injection[s], of diagnostic or therapeutic substance[s] [for example, anesthetic, antispasmodic, opioid, steroid, other solution], not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance [such as, fluoroscopy or CT]).
- 62322 **with modifier U5** (Injection[s], of diagnostic or therapeutic substance[s] [for example, anesthetic, antispasmodic, opioid, steroid, other solution], not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral [caudal]; without imaging guidance).
- 62323 **with modifier U5** (Injection[s], of diagnostic or therapeutic substance[s] [for example, anesthetic, antispasmodic, opioid, steroid, other solution], not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral [caudal]; with imaging guidance [such as, fluoroscopy or CT]).

Intrathecal Infusion Pumps for Treatment of Pain Trial Period

Intrathecal pumps for opioid delivery for the treatment of pain require that a trial period be completed prior to the implantation surgery. Providers are required to use one of the following CPT procedure codes, along with modifier U5, to designate the opioid pain medication trial period:

- 62320 **with modifier U5** (Injection[s], of diagnostic or therapeutic substance[s] [for example, anesthetic, antispasmodic, opioid, steroid, other solution], not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance).
- 62321 **with modifier U5** (Injection[s], of diagnostic or therapeutic substance[s] [for example, anesthetic, antispasmodic, opioid, steroid, other solution], not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance [such as, fluoroscopy or CT]).
- 62322 **with modifier U5** (Injection[s], of diagnostic or therapeutic substance[s] [for example, anesthetic, antispasmodic, opioid, steroid, other solution], not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral [caudal]; without imaging guidance).
- 62323 **with modifier U5** (Injection[s], of diagnostic or therapeutic substance[s] [for example, anesthetic, antispasmodic, opioid, steroid, other solution], not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral [caudal]; with imaging guidance [such as, fluoroscopy or CT]).

Claims submitted with the U5 modifier will be referenced by ForwardHealth clinicians when the provider seeks authorization for permanent pump implantation. Claims that do not include the U5 modifier will not be considered eligible trials for reference in requesting the permanent pump implantation.

Note: Trial periods for opioid delivery for the treatment of pain must last a minimum of 24 hours. A separate PA request is required for both the trial period and the implantation surgery of an IIP for the treatment of pain.

Permanent Implantation for Treatment of Spasticity or Pain

Providers are required to use one of the following CPT procedure codes to designate permanent implantation of an IIP for treatment of spasticity or pain:

- 62360 (Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir).
- 62361 (Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump).
- 62362 (Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming).

Screening doses, trial periods, and implantation surgeries that do not meet the PA approval criteria are noncovered. ForwardHealth will not reimburse providers for any charges related to noncovered pump implantation surgeries. Associated charges for the IIP device and facility charges will only be reimbursed if surgery services for the implantation of the pump have been approved and rendered.

Topic #582

Intrauterine Devices

Wisconsin Medicaid reimburses physicians separately for the IUD (intrauterine device) and IUD insertion and removal procedures. Reimbursement for the E&M (evaluation and management) office visit and necessary supplies are included in the reimbursement for the IUD insertion and removal procedures. Do not submit a claim for the E&M visit or the supplies unless another separate and distinct service is provided and documented in the member's medical record.

Providers are required to indicate the appropriate procedure code on claims for IUD insertion and removal procedures.

Topic #23178

Laser Interstitial Thermal Therapy

ForwardHealth covers LITT (Laser Interstitial Thermal Therapy) to treat the following identified clinical conditions:

- Relapsed brain metastasis
- Acute cerebrovascular insufficiency
- Radiation necrosis
- Secondary malignant neoplasm of the brain
- Epilepsy:
  - Resistant to medications
  - Originating from a well-defined area in the brain

ForwardHealth requires an approved PA (prior authorization) for coverage of all LITT procedures. A LITT procedure that does not meet the PA approval criteria is considered a noncovered service and any claims for service related to the LITT procedure will be denied.

When submitting PA requests or claims to ForwardHealth for LITT, providers are required to include one of the following CPT (Current Procedural Terminology) procedure codes:

- 61736 (Laser Interstitial Thermal Therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion)
- 61737 (Laser Interstitial Thermal Therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s))

The modifier -50 may be indicated along with procedure code 61737 if performed bilaterally.

The interactive maximum allowable fee schedule includes additional coverage information.

Topic #16477

Panniculectomy and Lipectomy Surgeries

Panniculectomy and lipectomy surgeries are covered by ForwardHealth with PA (prior authorization).

Panniculectomy, a procedure closely related to abdominoplasty, is the surgical excision of a redundant, large and/or long overhanging apron of skin and subcutaneous fat located in the lower abdominal area. The condition may accompany significant overstretching of the lax anterior abdominal wall and, hence, often occurs in morbidly obese individuals or following substantial weight loss.

Lipectomy is a surgical technique that is used to remove unwanted fat deposits from specific areas of the body. These areas include the chin, neck, cheeks, upper arms, above the breast, abdomen, buttocks, hips, thighs, knees, calves, and ankles. It is not a substitute for weight reduction, but it is a method of removing localized fat that does not respond to dieting and exercise. Covered lipectomy services are done to treat functional impairment.

Note: Abdominoplasty, also referred to as a "tummy tuck," is a surgical procedure that tightens lax anterior abdominal wall muscles and removes excess abdominal skin and fat. This procedure is not associated with functional improvements and is considered to be cosmetic. Abdominoplasty and liposuction are not covered by ForwardHealth, even when independent of, or incidental to, covered panniculectomy or lipectomy surgery.

Topic #12437

Pectus Excavatum or Pectus Carinatum Surgery

All pectus excavatum and pectus carinatum procedures require PA (prior authorization). A pectus excavatum or pectus carinatum procedure that does not meet the PA approval criteria is considered a noncovered service. Any charges related to the noncovered pectus excavatum or pectus carinatum procedure will not be reimbursed.

Providers may be reimbursed for pectus excavatum or pectus carinatum surgery using any of the following CPT (Current Procedural Terminology) procedure codes:

- 21740 (Reconstructive repair of pectus excavatum or carinatum; open)
- 21742 (Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach [Nuss procedure], without thoracoscopy)
- 21743 (Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach [Nuss procedure], with thoracoscopy)

Topic #19137

Prophylactic Mastectomy

ForwardHealth covers prophylactic mastectomies when medically necessary per Wis. Admin. Code § DHS 101.03(96m); however, PA (prior authorization) is required for coverage.

Prophylactic mastectomy is defined as the removal of the breast in the absence of malignant disease to reduce the risk of breast cancer occurrence. Prophylactic mastectomies may be considered for women thought to be at high risk of developing breast cancer.

ForwardHealth recommends that all candidates for prophylactic mastectomy undergo counseling by a health care professional trained in cancer risk assessment (for example, board-certified genetic counselor, cancer nurse). Cancer risk should be assessed through the following:

- A complete family history
- Use of the Gail, Claus, or other risk model
- Discussion of other risk-reducing options, such as increased surveillance or chemoprevention with tamoxifen or raloxifene

When submitting PA requests or claims for a prophylactic mastectomy, providers are required to include CPT (Current Procedural Terminology) procedure code 19303 (Mastectomy, simple, complete).

Topic #18257

Reduction Mammoplasty

Reduction mammoplasty for female members with breast hypertrophy (enlarged breasts) is covered by ForwardHealth with PA (prior authorization).

Reduction mammoplasty is clinically indicated for women 18 years of age or older with breast hypertrophy if all of the following are true:

- There is significant physical functional impairment.
- The procedure can be reasonably expected to improve the physical functional impairment.
- Signs and/or symptoms resulting from the breast hypertrophy have not responded adequately to any non-surgical interventions.

Surgery is considered cosmetic unless breast hypertrophy is causing significant pain, paresthesias, or ulceration. Reduction mammoplasty for asymptomatic members is considered cosmetic and noncovered.

Providers are required to use CPT (Current Procedural Terminology) procedure code 19318 (Reduction mammoplasty) when submitting claims for reduction mammoplasty. The diagnosis code for breast hypertrophy must be indicated.

All reduction mammoplasties require PA. ForwardHealth has established clinical criteria for approval of a PA request for reduction mammoplasty. Reduction mammoplasties that do not meet the PA approval criteria are considered noncovered. Any charges related to a noncovered reduction mammoplasty will not be reimbursed.

Note: For male members with excess breast tissue, ForwardHealth covers mastectomy for gynecomastia when medically necessary per Wis. Admin. Code § DHS 101.03(96m); however, PA is required.

Topic #586

Sterilizations

General Requirements

A sterilization is any surgical procedure performed with the **primary** purpose of rendering an individual permanently incapable of reproducing. The procedure may be performed in an "open" or laparoscopic manner. This does not include procedures that, while they may result in sterility, have a different purpose such as surgical removal of a cancerous uterus or cancerous testicles.

Providers should refer to the physician services maximum allowable fee schedule for allowable sterilization procedure codes.

Medicaid reimbursement for sterilizations is dependent on providers fulfilling all federal and state requirements and satisfactory completion of a Consent for Sterilization (DMS-1000 (05/2025)) form. There are no exceptions. Federal and state regulations require that:

- 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.

  Note: 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 or initialed and dated by the physician and/or member, as indicated in the completion instructions.

ForwardHealth requires all of these individuals to sign and date the completed form by hand (electronic signatures will not be accepted):

- The individual to be sterilized
- The interpreter, if one was provided
- The person who obtained the consent
- The physician who performed the sterilization procedure

If any of the required signatures or initials and dates are missing or incomplete, the form will be considered invalid and will be returned to the provider.

Note: ForwardHealth allows the use of off-site interpreters (using video technology or telephone) for assistance in the completion of this form. The off-site interpreter is required to sign and date the form by hand (electronic signatures will not be accepted, and the interpreter's ID number does not fulfill this requirement). A copy of the completed form can be sent to the off-site interpreter for his or her signature and then faxed back to the provider.

Providers' failure to comply with any of the sterilization requirements results in denial of the sterilization claims.

The completed consent form can be uploaded via the ForwardHealth Portal for electronically submitted claims or be attached to a paper 1500 Health Insurance Claim Form ((02/12)) to obtain reimbursement.

Claim Submission Requirements

ForwardHealth covers inpatient surgical sterilization procedures when informed consent requirements are met, and the sterilization is provided during the same hospital stay as labor and delivery.

When submitting institutional claims for inpatient sterilizations, providers must:

- Enter the appropriate sterilization diagnosis code or procedure code.
- Enter value code 24 with the monetary charges related to the sterilization.
- Enter the amounts for institutional services related to sterilization in the field for noncovered charges when informed consent and completion requirements are not met.

Retroactive Eligibility

If one or more of the federal requirements has not been met, including completing the consent form at least 30 days prior to the procedure, the sterilization service is considered not covered and the provider may not receive ForwardHealth reimbursement; however, the provider may bill the member. This policy applies to the sterilization procedure and any services related to the procedure.

To ensure reimbursement for sterilizations, providers are urged to use the Consent for Sterilization form before **all** sterilizations in the event that the patient obtains Medicaid retroactive eligibility.

Sterilization with Placement by Permanent Implant

The professional service for CPT (Current Procedural Terminology) procedure code 58565 (Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants) and the implantable device are reimbursed under separate procedure codes.

The professional service only is reimbursed under procedure code 58565. The implantable device is reimbursed under HCPCS (Healthcare Common Procedure Coding System) procedure code A4264 (Permanent implantable contraceptive intratubal occlusion device[s] and delivery). Providers are required to bill their usual and customary fee for services provided to Wisconsin Medicaid and BadgerCare Plus members.

Providers are required to complete and submit the Consent for Sterilization form when billing these services.

Topic #587

Temporomandibular Joint Surgery

Providers may submit claims for assessing TMJ (temporomandibular joint) dysfunction using an E&M (evaluation and management) visit procedure code. A TMJ office visit generally consists of the following for a member experiencing TMJ dysfunction:

- Comprehensive history
- Detailed and extensive clinical examination
- Diagnosis

- Treatment planning

Allowable Procedure Codes

Providers may refer to the maximum allowable fee schedules for the most current TMJ surgery and anesthesia services procedure codes.

Member Eligibility for Temporomandibular Surgery

A member must have received appropriate nonsurgical treatment that has not resolved or improved the member's condition to be considered eligible for TMJ surgery. Nonsurgical treatment may include the following:

- Short-term medication
- Home therapy (for example, soft diet)
- Splint therapy
- Physical therapy, including correction of myofunctional habits
- Relaxation or stress management techniques
- Psychological evaluation or counseling

Prior Authorization Requirements

Wisconsin Medicaid requires PA (prior authorization) for TMJ surgery.

The surgeon who will perform the TMJ surgery requests PA by using the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)), the PA/PA (Prior Authorization/Physician Attachment, F-11016 (07/2012)), 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.

Topic #584

Transplant Services

The following transplants are covered when they are appropriate and medically necessary and are provided in an approved hospital as determined by ForwardHealth:

- Cornea
- Heart
- Kidney

- Liver
- Lung
- Pancreas
- Small bowel
- Bone marrow, with PA (prior authorization)
- Hematopoietic stem cell, with PA
- Other medically-necessary transplants, with PA

Transplants involving combinations of the above solid organs (for example, heart-lung) are also covered.

Transplants must be performed in an approved UNOS (United Network for Organ Sharing) transplant center. Refer to the Data page of the Organ Procurement and Transplantation Network for UNOS-approved organ transplant centers.

Prior to making a referral to an approved transplant center, ForwardHealth recommends that physicians verify that the transplant center currently accepts Wisconsin Medicaid member referrals and Medicaid reimbursement for the proposed transplant.

Prior Authorization Requirements

For transplant services that require PA, the transplant center in which the transplant will occur is required to request PA, **not** the physician. The transplant center and the physician are encouraged to jointly complete the PA request.

Topic #588

Vagus Nerve Stimulator Implant Surgeries

VNS (Vagus nerve stimulation) is a safe and effective treatment for members with medical refractory partial onset seizures for whom other surgery is not an option or for whom surgery has failed.

VNS implant surgeries require PA (prior authorization). The rendering surgeon is required to obtain PA from ForwardHealth. ForwardHealth will deny claims for services and equipment related to the surgery unless there is an approved PA request on file from the rendering surgeon for the surgery. VNS implant surgeries that do not meet the PA approval criteria are considered noncovered. Any charges related to the noncovered VNS implant surgery will not be reimbursed.

The surgeon may receive separate reimbursement for the device if the surgery is performed in an outpatient hospital or ambulatory surgery center **and** the surgeon is Medicaid-enrolled as a DME (durable medical equipment) provider.

Telehealth

Topic #22737

Behavioral Health Telehealth Services

Behavioral health services should be indicated by these modifiers.

Modifier	Description
FQ*	A telehealth service was furnished using audio-only communication technology
FR*	A supervising practitioner was present through a real-time two-way, audio/video communication technology
GQ	Via asynchronous telecommunications system
GT	Via interactive audio and video telecommunication systems
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system

*Use for behavioral health services **only**.

Topic #22738

Interprofessional Consultations (E-Consults)

An interprofessional consultation or e-consult is an assessment and management service in which a member's treating provider requests the opinion and/or treatment advice of a provider with specific expertise (the consultant) to assist the treating provider in the diagnosis and/or management of the member's condition without requiring the member to have face-to-face contact with the consultant. Both the treating and consulting providers may be reimbursed for the e-consult as described below.

Policy Requirements and Limitations

Consulting Providers

Consulting providers must be physicians enrolled in Wisconsin Medicaid as an eligible rendering provider. Consulting providers may bill CPT (Current Procedural Terminology) procedure codes 99446–99449 and 99451 under the following limitations:

- Services are not covered if the consultation leads to a transfer of care or other face-to-face service within the next 14 days or next available date of the consultant. Additionally, if the sole purpose of the consultation is to arrange a transfer of care or other face-to-face service, these procedure codes should not be submitted.
- Consulting services are covered once in a seven-day period.

Treating Providers

Treating providers may be a physician, nurse practitioner, physician assistant, or podiatrist enrolled in Wisconsin Medicaid as an eligible rendering provider. Treating providers may bill CPT procedure code 99452 as a covered service once in a 14-day period.

Both the consulting and treating providers must be enrolled in Wisconsin Medicaid to receive reimbursement for the e-consult and

the consultation must be medically necessary.

Providers are expected to follow CPT guidelines including that the CPT procedure codes should not be submitted if the consulting provider saw the member in a face-to-face encounter within the previous 14 days.

Documentation Requirements

The following documentation requirements apply for e-consults:

- The consulting provider's opinion must be documented in the member's medical record.
- The written or verbal request for a consultation by the treating provider must be documented in the member's medical record including the reason for the request.
- Verbal consent for each consultation must be documented in the member's medical record. The member's consent must include assurance that the member is aware of any applicable cost-sharing.

Topic #22739

Originating and Distant Sites

The originating site is where the member is located during a telehealth visit. Only the provider at the originating site can bill for an originating site fee for hosting the member. The originating site should not use telehealth modifiers on the claims since all services are provided in-person. The distant site is where the provider is located during the telehealth visit. The provider who is providing health care services to the member via telehealth cannot bill the originating site fee because they are not hosting the member.

These locations are eligible for the originating site fee under permanent telehealth policy:

- Office or clinic:
  - Medical
  - Dental
  - Therapies (physical therapy, occupational therapy, speech and language pathology)
  - Behavioral and mental health agencies
- Hospital
- Skilled nursing facility
- Community mental health center
- Intermediate care facility for individuals with intellectual disabilities
- Pharmacy
- Day treatment facility
- Residential substance use disorder treatment facility

Claims Submission and Reimbursement for Distant Site Providers

Claims for services provided via telehealth by distant site providers must be billed with the same procedure code as would be used for a face-to-face encounter along with modifiers GQ, GT, FQ, 93, or 95.

Note: Only the service rendered from the distant site must be billed with modifier GQ. The originating site for asynchronous services is not eligible to receive an originating site fee.

Claims must also include either POS (place of service) code 02 or 10. ForwardHealth reimburses the service rendered by distant site providers at the same rate as when the service is provided face-to-face.

Ancillary Providers

Claims for services provided via telehealth by distant site ancillary providers should continue to be submitted under the supervising physician's NPI (National Provider Identifier) using the lowest appropriate level office or outpatient visit procedure code or other appropriate CPT (Current Procedural Terminology) code for the service performed. These services must be provided under the direct on-site supervision of a physician who is located at the same physical site as the ancillary provider and must be documented in the same manner as services that are provided face to face.

Refer to the Supervision topic for additional information.

Pediatric and Health Professional Shortage Area-Eligible Services

Claims for services provided via telehealth by distant site providers may additionally qualify for pediatric (services for members 18 years of age and under) or HPSA (Health Professional Shortage Area)-enhanced reimbursement. Pediatric and HPSA-eligible providers are required to indicate POS code 02 or 10, along with modifier GQ, GT, FQ, 93, or 95 and the applicable pediatric or HPSA modifier, when submitting claims that qualify for enhanced reimbursement.

Claims Submission and Reimbursement for Originating Site Fee

In addition to reimbursement to the distant site provider, ForwardHealth reimburses an originating site fee for the staff and equipment at the originating site requisite to provide a service via telehealth. Eligible providers who serve as the originating site should bill the fee with HCPCS (Healthcare Common Procedure Coding System) procedure code Q3014 (Telehealth originating site fee). Modifier GQ, GT, FQ, 93, or 95 should not be included with procedure code Q3014.

Outpatient hospitals, including emergency departments, must bill HCPCS procedure code Q3014 on an institutional claim form as a separate line item with revenue code 0780. ForwardHealth will reimburse hospitals for the fee based on the standard hospital reimbursement methodology. ForwardHealth will reimburse these providers for the fee based on the provider's standard reimbursement methodology.

All other providers should bill HCPCS procedure code Q3014 with a POS code that represents where the member is located during the service. The POS must be a ForwardHealth-allowable originating site for HCPCS procedure code Q3014 in order to be reimbursed for the originating site fee. Billing-only provider types must include an allowable rendering provider on the claim form. The originating site fee is reimbursed based on a maximum allowable fee.

Although FQHCs are not directly reimbursed an originating site fee, HCPCS procedure code Q3014 should be billed for tracking purposes and for consideration in any potential future changes in scope.

To receive reimbursement, the originating site must:

- Use an interactive audiovisual telecommunications system that permits real-time communication between the provider at the distant site and the member at the originating site.
- Be in a physical location that ensures privacy.
- Provide access to broadband internet with sufficient bandwidth to transmit audio and video data.
- Provide access to support staff to assist with technical components of the telehealth visit.
- Be compliant with Health Insurance Portability and Accountability Act of 1996 standards.

Federally Qualified Health Centers and Rural Health Clinics

For the purpose of this Online Handbook topic, FQHC (federally qualified health center) refers to Tribal and out-of-state FQHCs for encounters paid fee for service. This topic does not apply to Community Health Centers subject to PPS (prospective payment system) reimbursement or Tribal FQHCs subject to PPS or AIR (all-inclusive rate) reimbursement.

FQHCs and RHCs (rural health clinics) may serve as originating site and distant site providers for telehealth services.

Distant Site

FQHCs and RHCs may report services provided via telehealth on the cost settlement report when the FQHC or RHC served as the distant site and the member is an established patient of the FQHC or RHC at the time of the telehealth service. For currently covered services, services that are considered direct when provided in-person will be considered direct when provided via telehealth for FQHCs.

Services billed with modifier GQ, GT, FQ, 93, or 95 will be considered under the PPS reimbursement method for non-tribal FQHCs. Billing HCPCS procedure code T1015 (Clinic visit/encounter, all-inclusive) with a telehealth procedure code will result in a PPS rate for fee-for-service encounters. Fee-for-service claims must include HCPCS procedure code T1015 when services are provided via telehealth in order for proper reimbursement.

Originating Site

The originating site fee is not a FQHC or RHC reportable encounter on the cost report. Any reimbursement for the originating site fee must be reported as a deductive value on the cost report.

Topic #22740

Remote Patient Monitoring

Remote Physiologic Monitoring

Remote physiologic monitoring is the collection and interpretation of a member's physiologic data, such as blood pressure or weight checks, that are digitally transmitted to a physician, nurse practitioner, or physician assistant for use in the treatment and management of medical conditions that require frequent monitoring. Such conditions include congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, and mental or behavioral problems. It is also used for members receiving technology-dependent care, such as continuous oxygen, ventilator care, total parenteral nutrition, or enteral feeding.

Eligible Devices

The device used to capture a member's physiologic data must meet the Food and Drug Administration definition of a medical device. To submit claims for CPT (Current Procedural Terminology) procedure codes 99453–99458, the members' physiologic data must be wirelessly synced so it can be evaluated by the physician, nurse practitioner, or physician assistant. Transmission can be synchronous or asynchronous (data does not have to be transmitted in real time as long as it is automatically updated on an ongoing basis for the provider to review).

Policy Requirements

These policy requirements apply for remote physiologic monitoring services:

- Only physicians, nurse practitioners, and physician assistants enrolled in ForwardHealth are eligible to render and submit claims for remote physiologic services.
- The member's consent for remote physiologic monitoring services must be documented in the member's medical record.
- The provider must document how remote physiologic monitoring is tied to the member-specific needs and will assist the member to achieve the goals of treatment.
- Services are not separately reimbursable if the services are bundled or covered by other procedure codes (for example, continuous glucose monitoring is covered under CPT procedure code 95250 and should not be submitted under CPT procedure codes 99453–99454).
- CPT procedure codes 99445, 99453, and 99454 can be used for blood pressure remote physiologic monitoring if the

device used to measure blood pressure meets remote physiologic monitoring requirements. If the member self-reports blood pressure readings, the provider must instead submit self-measured blood pressure monitoring CPT procedure codes 99473–99474.

- CPT procedure code 99457 and 99470 should be used when the physician, nurse practitioner, or physician assistant uses medical decision making based on interpreted data received from a remote physiologic monitoring device to assess the member's clinical stability, communicate the results to the member, and oversee the management and/or coordination of services as needed.

Providers are expected to follow CPT guidelines.

Claim Submission

Special modifiers are not required or requested for remote physiologic monitoring services. Providers should follow appropriate claim submission requirements as outlined in the Online Handbook.

Topic #22757

Supervision

Supervision requirements and respective telehealth allowances vary depending on service and provider type. Some supervision requirements necessitate the physical presence of the supervising provider to meet the requirements of appropriate delivery of supervision. Such requirements cannot be met through the provision of telehealth, including audio-visual delivery.

Providers who deliver services with supervision requirements are reminded to review ForwardHealth policy, including permanent telehealth policy, and the requirements of their licensing and/or certifying authorities to determine if the supervisory components of the service can be met via telehealth.

Supervision of Paraprofessional Providers

Paraprofessional providers are subject to supervision requirements. Paraprofessional providers are providers who do not hold a license to practice independently but are providing services under the direction of a licensed provider. Providers who supervise paraprofessionals are responsible for confirming if the required components of supervision can be met through telehealth delivery.

Personal Care/Home Health Provider Supervision

Supervision of PCWs (personal care workers) and home health aides must be performed on site and in person by the RN (registered nurse). State rules and regulations necessitate supervising providers to physically visit a member's home and directly observe the paraprofessional providing services.

Direct Supervision for Ancillary Care Providers

Ancillary providers have specific requirements when providing care via telehealth. These providers are health care professionals that are not enrolled in Wisconsin Medicaid, such as staff nurses, dietician counselors, nutritionists, health educators, genetic counselors, and some nurse practitioners who practice under the direct supervision of a physician and bill under the supervising physician's NPI (National Provider Identifier). (Nurse practitioners, nurse midwives, and anesthetists who are Medicaid-enrolled should refer to their service-specific area of the Online Handbook for billing information).

For telehealth services, the supervising physician is not required to be onsite, but they must be able to interact with the member using real-time audio or audiovisual communication, if needed. For supervision of ancillary providers, remote supervision is allowed in circumstances where the physician feels the member is not at risk of an adverse event that would require hands-on intervention from the physician.

Supervision for Behavioral Health Services

The FR modifier should be used for behavioral health services where the supervising provider is present through audio-visual means and the patient and supervised provider are in-person.

Documenting Supervision Method

Providers should include how the service and the required supervision occurred in the member record and, if applicable, indicate the appropriate modifier on the claim form. For example, for a behavioral health service where the supervising provider is present through audio-visual means and the patient and supervised provider are in-person, modifier FR should be indicated on the claim.

Topic #22837

Telehealth Definitions

General Telehealth Definitions

Telehealth means the use of telecommunications technology by a Medicaid-enrolled provider to deliver functionally equivalent health care services including: assessment, diagnosis, consultation, treatment, and transfer of medically relevant data. Telehealth may include real-time interactive audio-only communication. Telehealth does not include communication between a provider and a member that consists solely of an email, text, or fax transmission.

Synchronous telehealth services are two-way, real-time, interactive communications. They may include audio-only (telephone) or audio-visual communications.

Asynchronous telehealth services are defined as telehealth that is used to transmit medical data about a patient to a provider when the transmission is not a two-way, real-time, interactive communication.

Functionally equivalent means that when a service is provided via telehealth, the transmission of information must be of sufficient quality as to be the same level of service as an in-person visit. Transmission of voices, images, data, or video must be clear and understandable.

Telehealth Service Definitions

The following are definitions to clarify the meaning of existing terms that describe different modes of telehealth service delivery in telehealth policy.

In-person refers to when the provider rendering a service and the member receiving that service are located together physically in the same space. In-person services are not considered to be delivered through telehealth, including audio-visual telehealth, unless there are applicable supervision components and requirements that are rendered through telehealth outside of the direct patient contact by the provider.

Face-to-face refers to requirements that can be met either in-person or through real-time, interactive audio-visual telehealth. An interactive telehealth service with face-to-face components must be functionally equivalent to an in-person service. It is delivered from outside the physical presence of a Medicaid member by using audio-visual technology, and there is no reduction in quality, safety, or effectiveness. ForwardHealth does not consider a face-to-face requirement to be met by audio-only or asynchronous delivery of services.

Under telehealth policy, **direct** refers to an in-person contact between a member and a provider. Direct services often require a provider to physically touch or examine the recipient and delegation is not appropriate.

Topic #510

Telehealth Policy

Both synchronous (two-way, real-time, interactive communications) and asynchronous (information stored and forwarded to a provider for later review) services identified under permanent policy may be reimbursed when provided via telehealth (also known as telemedicine). ForwardHealth will require providers to follow permanent billing guidelines for both synchronous and asynchronous telehealth services.

Telehealth enables a provider who is located at a distant site to render the service remotely to a member located at an originating site using a combination of interactive video, audio, and externally acquired images through a networking environment.

Telehealth means the use of telecommunications technology by a Medicaid-enrolled provider to deliver functionally equivalent health care services including assessment, diagnosis, consultation, treatment, and transfer of medically relevant data. Telehealth may include real-time interactive audio-only communication. Telehealth does not include communication between a provider and a member that consists solely of an email, text, or fax transmission.

Functionally equivalent means that when a service is provided via telehealth, the transmission of information must be of sufficient quality as to be the same level of service as an in-person visit. Transmission of voices, images, data, or video must be clear and understandable.

Note: Temporary telehealth policy that will become permanent policy shortly after the Federal Health Emergency expires is included in this topic.

Telehealth Policy Requirements

The following requirements apply to the use of telehealth:

- Both the member and the provider of the health care service must agree to the service being performed via telehealth. If either the member or provider decline the use of telehealth for any reason, the service should be performed in-person.
- The member retains the option to refuse the delivery of health care services via telehealth at any time without affecting their right to future care or treatment and without risking the loss or withdrawal of any program benefits to which they would otherwise be entitled.
- Medicaid-enrolled providers must be able and willing to refer members to another provider if necessary, such as when telehealth services are not appropriate or cannot be functionally equivalent, or the member declines a telehealth visit.
- Title VI of the Civil Rights Act of 1964 requires recipients of federal financial assistance to take reasonable steps to make their programs, services, and activities accessible by eligible persons with limited English proficiency.
- The Americans with Disabilities Act requires that health care entities provide full and equal access for people with disabilities.

Allowable Services

The Max Fee Schedules include a complete list of services allowed under permanent telehealth policy. Procedure codes for services allowed under permanent telehealth policy have POS codes 02 and 10 listed as an allowable POS in the fee schedule. Complete descriptions of these POS codes are as follows:

- POS code 02: Telehealth Provided Other Than in Patient's Home–The location where health services and health related services are provided or received through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.
- POS code 10: Telehealth Provided in Patient's Home–The location where health services and health related services are

provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.

Claims for services delivered via telehealth must include all modifiers required by the existing benefit coverage policy in order to reimburse the claim correctly. Telehealth delivery of the service is shown on the claim by indicating POS code 02 or 10 and including a telehealth modifier in addition to any other required benefit-specific modifiers, unless the procedure code includes the method of delivery in the official procedure code description.

County-administered programs, school-based services, and any other programs that utilize cost reporting must include required modifiers, such as renderer credentials and group versus individual services, as well as correct details for cost reporting to ensure correct reimbursement.

Services Not Appropriate via Telehealth

Certain types of benefits or services that are not appropriately delivered via telehealth include:

- Services that are not covered when provided in-person.
- Services that do not meet applicable laws, regulations, licensure requirements, or procedure code definitions if delivered via telehealth.
- Services where a provider is required to physically touch or examine the recipient and delegation is not appropriate.
- Services the provider declines to deliver via telehealth.
- Services the recipient declines to receive via telehealth.
- Transportation services.
- Services provided by personal care workers, home health aides, private duty nurses, or school-based service care attendants.

Reimbursement for Covered Services

The health care provider at the distant site must determine:

- The service delivered via telehealth meets the procedural definition and components of the CPT or HCPCS procedure code, as defined by the American Medical Association, or the CDT (Current Dental Terminology) procedure code, as defined by the American Dental Association.
- The service is functionally equivalent to an in-person service for the individual member and circumstances.

Reimbursement is not available for services that cannot be provided via telehealth due to technical or equipment limitations.

Documentation Requirements

Documentation requirements for a telehealth service are the same as for an in-person visit and must accurately reflect the service rendered. Documentation must identify the delivery mode of the service when provided via telehealth and document:

- Whether the service was provided via audio-visual telehealth, audio-only telehealth, or via telehealth externally acquired images
- Whether the service was provided synchronously or asynchronously

Additional information for which documentation is recommended, but not required, includes:

- Provider location (for example, clinic [city/name], home, other)
- Member location (for example, clinic [city/name], home)
- All clinical participants, as well as their roles and actions during the encounter (This could apply if, for example, a member

presents at a clinic and receives telehealth services from a provider at a different location.)

As a reminder, documentation for originating sites must support the member's presence in order to submit a claim for the originating site fee. In addition, if the originating site provides and bills for services in addition to the originating site fee, documentation in the member's medical record should distinguish between the unique services provided.

Audio-Only Guidelines

When possible, telehealth services should include both an audio and visual component. In circumstances where audio-visual telehealth is not possible due to member preference or technology limitations, telehealth may include real-time interactive audio-only communication if the provider feels the service is functionally equivalent to the in-person service and there are no face-to-face or in-person restrictions listed in the procedural definition of the service.

Documentation should include that the service was provided via interactive synchronous audio-only telehealth.

Modifier 93 should be used for any service performed via audio-only telehealth. The GT modifier should only be used to indicate services that were performed using audio-visual technology.

Member Consent Guidelines for Telehealth

On at least an annual basis, providers should supply and document that:

- The member expressed an understanding of their right to decline services provided via telehealth.
- Providers should develop and implement their own methods of informed consent to verify that a member agrees to receive services via telehealth. These methods must comply with all federal and state regulations and guidelines.
- Providers have flexibility in determining the most appropriate method to capture member consent for telehealth services. Examples of allowable methods include educating the member and obtaining verbal consent prior to the start of treatment or telehealth consent and privacy considerations as part of the notice of privacy practices.

Privacy and Security

Providers are required to follow federal laws to ensure member privacy and security. This may include ensuring that:

- The location from which the service is delivered via telehealth protects privacy and confidentiality of member information and communications.
- The platforms used to connect to the member to the telehealth visit are secure.

Group Treatment

Additional privacy considerations apply to members participating in group treatment via telehealth. Group leaders should provide members with information on the risks, benefits, and limits to confidentiality related to group telehealth and document the member's consent prior to the first session. Group leaders should adhere to and uphold the highest privacy standards possible for the group.

Group members should be instructed to respect the privacy of others by not disclosing group members' images, names, screenshots, identifying details, or circumstances. Group members should also be reminded to prevent non-group members from seeing or overhearing telehealth sessions.

Providers may not compel members to participate in telehealth-based group treatment and should make alternative services available for members who elect not to participate in telehealth-based group treatment.

Costs Member Cannot Be Billed For

The following cannot be billed to the member:

- Telehealth equipment like tablets or smart devices
- Charges for mailing or delivery of telehealth equipment
- Charges for shipping and handling of:
  - Diagnostic tools
  - Equipment to allow the provider to assess, diagnose, repair, or set up medical supplies online such as hearing aids, cochlear implants, power wheelchairs, or other equipment

Allowable Providers

There are no limitations on what provider types may be reimbursed for telehealth services.

Requirements and Restrictions

Services provided via telehealth must be of sufficient audio and visual fidelity and clarity as to be functionally equivalent to a face-to-face visit where both the rendering provider and member are in the same physical location. Both the distant and originating sites must have the requisite equipment and staffing necessary to provide the telehealth service.

Coverage of a service provided via telehealth is subject to the same restrictions as when the service is provided face to face (for example, allowable providers, multiple service limitations, PA (prior authorization)).

Providers are reminded that HIPAA (Health Insurance Portability and Accountability Act of 1996) confidentiality requirements apply to telehealth services. When a covered entity or provider utilizes a telehealth service that involves PHI (protected health information), the entity or provider will need to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to PHI confidentiality, integrity, and availability. Each entity or provider must assess what are reasonable and appropriate security measures for their situation.

Note: Providers may not require the use of telehealth as a condition of treating a member. Providers must develop and implement their own methods of informed consent to verify that a member agrees to receive services via telehealth. These methods must comply with all federal and state regulations and guidelines.

Noncovered Services

Services that are not covered when delivered in person are not covered as telehealth services. In addition, services that are not functionally equivalent to the in-person service when provided via telehealth are not covered.

Additional Policy for Certain Types of Providers

Out-of-State Providers

ForwardHealth policy for services provided via telehealth by out-of-state providers is the same as ForwardHealth policy for services provided face to face by out-of-state providers.

Out-of-state providers who meet the definition of a border-status provider as described in Wis. Admin. Code § DHS 101.03(19) and who provide services to Wisconsin Medicaid members only via telehealth, may apply for enrollment as Wisconsin telehealth-only border-status providers if they are licensed in Wisconsin under applicable Wisconsin statute and administrative code.

Out-of-state providers who do not have border status enrollment with Wisconsin Medicaid are required to obtain PA before providing services via telehealth to BadgerCare Plus or Medicaid members.

Note: Wisconsin Medicaid is prohibited from paying providers located outside of the United States and its territories, including the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

Topic #22741

Telestroke Services

Telestroke, also known as stroke telemedicine, is a delivery mechanism of telehealth services that aims to improve access to recommended stroke treatment.

ForwardHealth allows providers to be reimbursed for telestroke services. Telestroke services typically consist of the member and emergency providers at an originating site consulting with a specialist located at a distant site.

Claims Submission for Telestroke Services

Providers are required to use CPT (Current Procedural Terminology) consultation and E&M (evaluation and management) procedure codes when billing telestroke services. Telestroke services are subject to the same enrollment policy, coverage policy, and billing policy as telehealth services. All other services rendered by the provider at the originating site, and by any providers to which the member is transferred, should be billed in the same manner as visits or admissions that do not involve telehealth services.

Originating sites that have established contractual relationships for telestroke services may bill as they would for any other contracted professional services for both the professional service claim on behalf of the distant site provider and the originating site fee.

Topic #22742

Virtual Check-In, E-Visit, and Telemedicine Evaluation and Management Services

ForwardHealth includes virtual check-in and e-visit options for members to connect with their providers remotely.

A **virtual check-in** is a brief patient-initiated asynchronous or synchronous communication and technology-based service intended to be used to decide whether an office visit or other service is needed. The encounter may involve synchronous discussion over a phone or exchange of information through video or image. A provider may respond to the member's concern by phone, audio-visual communications, or a secure patient portal. Covered services include both the remote evaluation of a recorded video or image submitted by a member and the interpretation and follow-up by the provider.

An **e-visit** is a communication between a member and their provider through an online HIPAA (Health Insurance Portability and Accountability Act of 1996)-compliant patient portal. These patient-initiated asynchronous services involve a member having non-face-to-face communications cumulatively over a span of seven days with a provider with whom they have an established relationship. Providers who can bill E&M (evaluation and management) services may utilize online digital E&M codes while other providers may be eligible to bill online assessment and management codes.

Allowable procedure codes for virtual check-in and e-visit services:

Virtual Check-In Procedure Code	Description
Physician Services	

G2010	Remote evaluation of recorded video and/or images submitted by an established patient (eg, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E&M service provided within the previous seven days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment
G2252	Brief communication technology-based service (eg, virtual check-in), by a physician or other qualified health care professional who can report Evaluation and Management services, provided to an established patient, not originating from a related E&M service provided within the previous seven days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 11–20 minutes of medical discussion
Therapies (PT, OT, SLP) Services	
G2250	Remote assessment of recorded video and/or images submitted by an established patient (eg, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous seven days nor leading to a service or procedure within the next 24 hours or soonest available appointment
G2251	Brief communication technology-based service (eg, virtual check-in), by a qualified health care professional who cannot report Evaluation and Management services, provided to an established patient, not originating from a related service provided within the previous seven days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of clinical discussion

E-Visit Procedure Code	Description
Therapies (PT, OT, SLP) Services	
98970	Nonphysician qualified health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
98971	Nonphysician qualified health care professional online digital assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11–20 minutes
98972	Nonphysician qualified health care professional online digital assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
Physician Services	
99421	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; 5–10 minutes
99422	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; 11–20 minutes
99423	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes

These services do not require prior authorization and are patient-initiated by established patients of the provider's practice.

Virtual check-in and e-visit telehealth services are not covered or billable if they:

- Take place during an in-person visit.
- Take place within seven days after an in-person visit furnished by the same provider.

- Trigger an in-person visit within 24 hours or the soonest available appointment.
- Do not have sufficient information from the remote evaluation of an image or video (store and forward) for the provider to complete the service.

Only the relevant in-person procedure code that was rendered would be reimbursed if any of the above conditions apply.

Telemedicine Evaluation and Management Services

ForwardHealth allows the following procedure codes to be reimbursable for telemedicine E&M services:

Telemedicine Services Procedure Code	Description
98000	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
98001	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98002	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98003	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
98004	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
98005	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98006	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98007	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
98008	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

98009	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98010	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98011	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
98012	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.
98013	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98014	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98015	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
98016	Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion.

Managed Care

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Archive Date:10/01/2026

Managed Care:Claims

Topic #384

Appeals to BadgerCare Plus/Medicaid SSI HMOs and Children's Specialty Managed Care PIHPs

BadgerCare Plus/Medicaid SSI HMO and Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) contracted and non-contracted providers are required to first file an appeal directly with the HMO/PIHP after the initial payment denial or reduction. Providers should refer to their signed contract with the HMO/PIHP or the HMO's/PIHP's website for specific filing timelines and responsibilities (for example, PA (prior authorization), claim filing timelines, and coordination of benefits requirements) pertaining to filing a claim reconsideration and/or filing a formal appeal. The provider's signed contract with the HMO/PIHP may dictate the final decision. Filing a claim reconsideration is not the same as filing a formal appeal.

Appeal documents must reach the HMO/PIHP within the time frame established by the HMO/PIHP. Special care should be taken to ensure the documents reach the HMO/PIHP by the timely, filing deadline by allowing enough time for U.S. Postal Service mail handling or by using a verifiable delivery method (for example, secure Portal, fax, certified mail, or secure email).

The HMO/PIHP has 45 calendar days to respond in writing to a formal appeal. The HMO/PIHP decides whether to pay the claim and sends a letter stating this decision. If the HMO/PIHP does not respond in writing within 45 calendar days or the provider is dissatisfied with the HMO's/PIHP's response, the provider may submit an appeal to ForwardHealth through the Provider Appeals portal within 60 calendar days from the end of the 45 calendar day timeline or the date of the HMO/PIHP response.

Topic #385

Appeals to ForwardHealth

ForwardHealth **will not review** appeals that were not first made to the BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan). If a provider sends an appeal directly to ForwardHealth without first filing it with the HMO/PIHP, the appeal will be returned to the provider., and the payment denial or reduction will be upheld.

The provider has 60 calendar days to file an appeal with ForwardHealth after the HMO/PIHP either does not respond in writing within 45 calendar days, or if the provider is dissatisfied with the HMO/PIHP response.

Appeals will only be reviewed for enrollees who were eligible for and who were enrolled in an HMO/PIHP on the DOS (date of service) in question.

Once all pertinent information is received, ForwardHealth has 45 calendar days to make a final decision. The provider and the HMO/PIHP will be notified by ForwardHealth of the final decision. If the decision is in the provider's favor, the HMO/PIHP is required to pay the provider within 45 calendar days of the final decision. The decision is final, and all parties are required to abide by the decision.

Providers are required to submit an appeal to ForwardHealth through the Provider Appeals portal.

How to Begin Using the Provider Appeals Portal

Providers who contract with a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP and who need to appeal a claim decision will be required to register and set up a Provider Appeals portal account. Note: This portal account is separate from a provider's secure ForwardHealth Portal account.

To register for a Provider Appeals portal account, providers and HMOs/PIHPs can access the Provider Appeals portal. Providers are required to complete and submit the registration form, available by clicking either the HMO Registration or Provider Registration button (as applicable) on the Provider Appeals portal home page. Examples of information required to complete the registration process include the following:

- The provider's Medicaid ID or both their NPI (National Provider Identifier) and taxonomy code
- Provider ZIP+4 code
- DOS for the appeal
- Contact information (name, email, phone number) for the person registering

Once ForwardHealth receives and processes the registration form, an account login ID and associated PIN (provider identification number) will be created. Providers will receive an email message with their Provider Appeals portal login ID and will receive their PIN information in a mailed letter.

Note: Third party administrators and out-of-state providers must call the EDI (Electronic Data Interchange) Helpdesk at 866-417-4979 or send an email to vedswiedi@wisconsin.gov to begin registration.

More information on registering for and using the Provider Appeals portal and additional portal resources, including the Provider Appeals Portal User Guide, is available.

Portal Functionality

Providers can use the ForwardHealth appeals process through the Provider Appeals portal after exhausting the HMO/PIHP payment dispute process. Providers are required to use the Provider Appeals portal to:

- Submit an appeal to ForwardHealth for a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP claim payment denial or reduced payment.
- Submit documentation.
- Check the status of an appeal.
- Respond to requests for additional information.
- View decision notices.

For assistance regarding submission of an appeal through the ForwardHealth Portal, providers can call the ForwardHealth Managed Care Unit at 800-760-0001, option 1.

Required Documentation

When submitting an appeal to ForwardHealth through the Provider Appeals portal, the following documentation must be submitted/attached in required fields:

- The original claim submitted to the HMO/PIHP and all corrected claims submitted to the HMO/PIHP
- All of the HMO's/PIHP's payment denial remittances showing the dates of denial and reason codes with descriptions of the exact reasons for the claim denial
- The provider's written appeal to the HMO/PIHP
- The HMO's/PIHP's response to the appeal
- Relevant medical documentation for appeals regarding coding issues or emergency determination that supports the appeal (Providers should only submit relevant documentation that supports the appeal. Large medical records submitted with no indication of where supporting information is found will not be reviewed.)

- Any contract language that supports the provider's appeal with the exact language that supports overturning the payment denial indicated (Contract language submitted with no indication of where supporting information is found will not be reviewed, and the denial will be upheld.)
- Any other documentation that supports the appeal (for example, commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort)

Only relevant documentation should be included.

Appeal Decisions

A decision to uphold the HMO's/PIHP's original payment denial or to overturn the denial will be made based on the documentation submitted to ForwardHealth for review. Failure to submit the required documentation or submitting incomplete, insufficient, or illegible documentation may lead to the original denial being upheld. The decision to overturn an HMO's/PIHP's denial must be clearly supported by the documentation.

If the HMO/PIHP subsequently overturns their original denial and reprocesses and pays the claim for which an appeal has been submitted, providers must contact the ForwardHealth Managed Care Unit at 800-760-0001, option 1, and request that the appeal be withdrawn.

To check on the status of an appeal submitted to ForwardHealth, providers can:

- Access the Provider Appeals portal.
- Call the ForwardHealth Managed Care Unit at 800-760-0001, option 1.

Topic #386

Claims Submission

BadgerCare Plus/Medicaid SSI HMOs and Children's Specialty Managed Care PIHPs (Prepaid Inpatient Health Plans) have requirements for timely filing of claims, and providers are required to follow the HMO/PIHP claims submission guidelines for each organization. Providers should contact the enrollee's HMO/PIHP for organization-specific submission deadlines.

Topic #387

Extraordinary Claims

Extraordinary claims are BadgerCare Plus or Medicaid claims for a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) enrollee that have been denied by an HMO/PIHP but may be paid as fee-for-service claims.

These are some examples of extraordinary claims situations:

- The enrollee was not enrolled in an HMO/PIHP at the time they were admitted to an inpatient hospital, but then they enrolled in an HMO/PIHP during the hospital stay. In this case, all claims related to the stay (including professional claims) should be submitted to fee for service. For the professional claims associated with the inpatient hospital stay, the provider is required to include the date of admittance and date of discharge in Item Number 18 of the paper 1500 Health Insurance Claim Form ((02/12)).
- The claims are for orthodontia/prosthodontia services that began before HMO/PIHP coverage. The provider must include a record with the claim indicating when the bands were placed.

Submitting Extraordinary Claims

When submitting an extraordinary claim, providers must include:

- A legible copy of the completed claim form in accordance with billing guidelines.
- A letter detailing the problem, any claim denials, and any steps taken to correct the situation.
- A copy of the Explanation of Medical Benefits form as applicable.

Submit extraordinary claims to:

ForwardHealth
Extraordinary Claims
313 Blettner Blvd
Madison WI 53784

Topic #388

Medicaid as Payer of Last Resort

Wisconsin Medicaid is the payer of last resort for most covered services, even when a member is enrolled in a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan). Before submitting claims to HMOs/PIHPs, providers are required to submit claims to other health insurance sources. Providers should contact the enrollee's HMO/PIHP for more information about billing other health insurance sources.

Topic #389

Provider Appeals

When a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) denies a provider's claim, the HMO/PIHP is required to send the provider a notice informing them of the right to file an appeal.

An HMO/PIHP network or non-network provider may file an appeal to the HMO/PIHP when:

- A claim submitted to the HMO/PIHP is denied payment.
- The full amount of a submitted claim is not paid.

Providers are required to file an appeal with the HMO/PIHP **before** filing an appeal with ForwardHealth.

Covered and Noncovered Services

Topic #16197

Care4Kids Program Benefit Package

Covered Services

Members enrolled in the Care4Kids program are eligible to receive all medically necessary services covered under Wisconsin Medicaid; however, Care4Kids will have the flexibility to provide services in a manner that best meets the unique needs of children in out-of-home care, including streamlining PA (prior authorization) requirements and offering select services in home settings. Members will also be allowed to go to any Medicaid-enrolled provider for emergency medical services or family planning services.

Noncovered Services

The following services are not provided as covered benefits through the Care4Kids program, but can be reimbursed for eligible Medicaid members on a fee-for-service basis:

- Behavioral treatment
- Chiropractic services
- CRS (Community Recovery Services)
- CSP (Community Support Programs)
- CCS (Comprehensive Community Services)
- Crisis intervention services
- Directly observed therapy for individuals with tuberculosis
- MTM (Medication therapy management)
- NEMT (Non-emergency medical transportation) services
- Prescription and over-the-counter drugs and diabetic supplies dispensed by the pharmacy
- Physician-administered drugs and their administration
- SBS (School-based services)
- Targeted case management

Children's Hospital of Wisconsin will establish working relationships, defined in writing through a memorandum of understanding, with providers of the following services:

- CSP
- CCS
- Crisis intervention services
- SBS
- Targeted case management services

Providers of these services must coordinate with Care4Kids to help assure continuity of care, eliminate duplication, and reduce fragmentation of services.

Topic #390

Covered Services

HMOs

HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements. Although ForwardHealth requires contracted HMOs and Medicaid SSI HMOs to provide all medically necessary covered services, the following services may be provided by BadgerCare Plus HMOs at their discretion:

- Dental
- Chiropractic

If the HMO does not include these services in their benefit package, the enrollee receives the services on a fee-for-service basis.

Topic #391

Noncovered Services

The following services are not covered by BadgerCare Plus HMOs or Medicaid SSI HMOs but are provided to members on a fee-for-service basis as long as ForwardHealth covers the service for the member, and the service is medically necessary:

- Behavioral treatment services (for example, autism services)
- Chiropractic services, unless the HMO elects to provide chiropractic services
- County-based mental health programs, including CCS (comprehensive community services), CRS (Community Recovery Services), CSP (community support program) benefits, and crisis intervention services
- Dental

  Note: HMOs must provide dental services in Milwaukee, Waukesha, Racine, Kenosha, Ozaukee, and Washington counties.

- Environmental lead investigation services provided through local health departments
- Hub and Spoke Health Home or SUD (substance use disorder) pilot programs (integrated recovery support services)
- Medication therapy management
- Pharmacy services and diabetic supplies
- PNCC (Prenatal care coordination) services
- Physician-administered drugs

  Note: The Physician-Administered Drugs Carve-Out Procedure Codes table indicates the status of procedure codes considered under the physician-administered drugs carve-out policy.

- Residential SUD treatment
- SBS (School-based services)
- Targeted case management services
- NEMT (Non-emergency medical transportation) services
- DOT (Directly observed therapy) and monitoring for TB (tuberculosis)-Only Services

Providers who render any of these services to a BadgerCare Plus or Medicaid SSI HMO member should submit PA (prior authorization) requests and claims directly to ForwardHealth for coverage.

Enrollment

Topic #392

Disenrollment and Exemptions

In some situations, a member may be exempt from enrolling in a BadgerCare Plus HMO or Medicaid SSI HMO. Exempted members receive health care under fee-for-service. Exemptions allow members to complete a course of treatment with a provider who is not contracted with BadgerCare Plus HMO or SSI HMOs. For example, in certain circumstances, members seeing a specialist when they are enrolled in an HMO **may** qualify for an exemption if their specialty provider is not in the HMO networks.

The contracts between Wisconsin DHS (Department of Health Services) and the HMOs provide more detail on the exemption and disenrollment requirements.

Topic #397

Enrollment Eligibility

BadgerCare Plus HMOs

Members enrolled in BadgerCare Plus are eligible for enrollment in a BadgerCare Plus HMO.

An individual who receives Tuberculosis-Related Medicaid, SeniorCare, or Wisconsin Well Woman Medicaid cannot be enrolled in a BadgerCare Plus HMO.

Information about a member's HMO enrollment status and other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) coverage may be verified by using Wisconsin's EVS (Enrollment Verification System) or the ForwardHealth Portal.

SSI HMOs

Members of the following subprograms are eligible for enrollment in a Medicaid SSI HMO:

- Individuals ages 19 and older who meet the SSI and SSI-related disability criteria
- Dual eligibles for Medicare and Medicaid

Individuals who are living in an institution, nursing home, or participating in a Home and Community-Based Waiver program are not eligible to enroll in an SSI MCO.

Topic #394

Enrollment Periods

BadgerCare Plus HMOs

Eligible enrollees are sent enrollment packets that explain the BadgerCare Plus HMOs and the enrollment process and provide

contact information. Once enrolled in a BadgerCare Plus HMO, members may change their HMO assignment within the first 90 days of enrollment in an HMO (whether they chose the HMO or were auto-assigned). If an enrollee no longer meets the criteria, they will be disenrolled from the HMO.

SSI HMOs

Eligible enrollees are sent enrollment packets that explain the Medicaid SSI HMO enrollment process and provide contact information. Once enrolled in an SSI HMO, members may change their HMO assignment within the first 90 days of enrollment in an HMO (whether they chose the HMO or were auto-assigned).

Topic #395

Enrollment Specialist

The Enrollment Specialist provides objective enrollment, education, outreach, and advocacy services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees. The Enrollment Specialist is a knowledgeable single point of contact for enrollees, solely dedicated to managed care issues. The Enrollment Specialist is not affiliated with any health care agency.

The Enrollment Specialist provides the following services to HMO and SSI HMO enrollees:

- Education regarding the correct use of HMO and SSI HMO benefits
- Telephone and face-to-face support
- Assistance with enrollment, disenrollment, and exemption procedures

Topic #398

Member Enrollment

HMOs

BadgerCare Plus HMO enrollment is either mandatory or voluntary based on ZIP code-defined enrollment areas as follows:

- Mandatory enrollment — Enrollment is mandatory for eligible members who reside in ZIP code areas served by two or more BadgerCare Plus HMOs. Some members may meet criteria for exemption from BadgerCare Plus HMO enrollment.
- Voluntary enrollment — Enrollment is voluntary for members who reside in ZIP code areas served by only one BadgerCare Plus HMO.

Members living in areas where enrollment is mandatory are encouraged to choose their BadgerCare Plus HMO. Automatic assignment to a BadgerCare Plus HMO occurs if the member does not choose a BadgerCare Plus HMO. In general, all members of a member's immediate family eligible for enrollment must choose the same HMO.

Members in voluntary enrollment areas can choose whether or not to enroll in a BadgerCare Plus HMO. There is no automatic assignment for members who live within ZIP codes where enrollment is voluntary.

SSI HMOs

Medicaid SSI HMO enrollment is either mandatory or voluntary as follows:

- Mandatory enrollment — Most SSI and SSI-related members are required to enroll in an SSI HMO. A member may choose the SSI HMO in which he or she wishes to enroll.

- Voluntary enrollment — Some SSI and SSI-related members may choose to enroll in an SSI HMO on a voluntary basis.

Topic #393

Member Grievances

Members have the right to file a grievance with their HMO if they are unsatisfied with the services of the HMO or its providers. A member can file a grievance at any time for issues like:

- Service quality.
- Disrespect from a provider or an employee.
- Violations of their member rights.

Members should contact the Wisconsin HMO Ombudsman Program to help solve the problem or write a formal grievance to the HMO. The SSI External Advocate can help SSI HMO members with filing a grievance.

Topic #396

Ombudsman Program

The Ombudsmen, or Ombuds, are resources for enrollees who have questions or concerns about their BadgerCare Plus HMO or Medicaid SSI HMO. Ombuds provide advocacy and assistance to help enrollees understand their rights and responsibilities in the grievance and appeal process.

Ombuds can be contacted at the following address:

BadgerCare Plus HMO/Medicaid SSI HMO Ombudsmen
PO Box 6470
Madison WI 53716-0470

Topic #399

Release of Billing or Medical Information

ForwardHealth supports BadgerCare Plus HMO and Medicaid SSI HMO enrollee rights regarding the confidentiality of health care records. ForwardHealth has specific standards regarding the release of an HMO or SSI HMO enrollee's billing information or medical claim records.

Managed Care Information

Topic #401

BadgerCare Plus HMO Program

An HMO is a system of health care providers that provides a comprehensive range of medical services to a group of enrollees. HMOs receive a fixed, prepaid amount per enrollee from ForwardHealth (called a capitation payment) to provide medically necessary services.

BadgerCare Plus HMOs are responsible for providing or arranging all contracted covered medically necessary services to enrollees. BadgerCare Plus members enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service members; however, HMOs may establish their own requirements regarding PA (prior authorization), claims submission, adjudication procedures, etc., which may differ from fee-for-service policies and procedures. BadgerCare Plus HMO network providers should contact their HMO for more information about its policies and procedures.

Topic #16177

Care4Kids Program Overview

Care4Kids is a health care program for children and youth in out-of-home care in Wisconsin. The Care4Kids program will offer comprehensive, coordinated services that are intended to improve the quality and timeliness of and access to health services for these children.

The Care4Kids program will serve children in out-of-home care placements (other than residential care centers) in Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties. Member participation will be voluntary, and enrollment will be allowed to continue for up to 12 months after the child leaves the out-of-home care system, as long as the child remains Medicaid-eligible and resides within one of the six counties.

Care4Kids is required to provide at least the same benefits as those provided under fee-for-service arrangements.

Program Administration

Children's Hospital of Wisconsin is currently the only integrated health system certified by ForwardHealth to administer the Care4Kids program. Children's Hospital of Wisconsin will be responsible for providing or arranging for the provision of all services covered under Medicaid, with a small number of exceptions. The services not included in the Care4Kids program will be reimbursed as fee-for-service benefits. Children's Hospital of Wisconsin's integrated network of health care providers, which includes specialty and primary care physicians and clinics within the Children's Hospital System as well as providers who are participating in CCHP (Children's Community Health Plan), is intended to provide coordinated care and services to meet the individualized needs of each of the children enrolled across multiple disciplines, including physical, behavioral health, and dental care.

Care4Kids will be responsible for providing or arranging for the provision of all medically necessary services covered by Wisconsin Medicaid to enrollees. Providers are required to be part of the CCHP network to get reimbursed by Care4Kids. Providers interested in being a part of the network should contact CCHP. Out-of-network providers are required to call Care4Kids prior to providing services to a Care4Kids enrollee. In situations where emergency medical services are needed, out-of-network providers are required to contact Care4Kids within 24 hours of providing services.

Member Enrollment Verification

Providers should verify a member's enrollment before providing services to determine if the member is enrolled in Care4Kids. Members enrolled in Care4Kids will present a ForwardHealth member identification card.

Providers verifying enrollment on the ForwardHealth Portal will see Care4Kids under the MC Program heading in the Managed Care Enrollment panel.

For 271 response transactions, Care4Kids enrollment will be identified in the EB segment of the 2110C loop. Identified by MC in the EB01, HM in the EB04, and Care4Kids in the EB05. The MC provider contact information will be reported in the NM1 (name info), N3 (address info), and PER (telephone numbers) segments within the 2120C loop.

The WiCall AVR (automated voice response) system will identify Care4Kids as the state-contracted managed care program in which the member is enrolled.

Contact Information

Providers can contact CCHP at 800-482-8010 for the following:

- To become part of the CCHP network
- For coverage policy and procedure information, including PA (prior authorization) and claim submission guidelines, if they are already a Care4Kids network provider

Topic #405

Managed Care

Managed Care refers to the BadgerCare Plus HMO program, the Medicaid SSI HMO program, and the following MLTC (managed long-term care) programs available: Family Care, Family Care Partnership, and PACE (Program of All-Inclusive Care for the Elderly).

The primary goals of the managed care programs are:

- To improve the quality of member care by providing continuity of care and improved access.
- To reduce the cost of health care through better care management.

Topic #402

Managed Care Contracts

The contract between the Wisconsin DHS (Department of Health Services) and the BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) takes precedence over other ForwardHealth provider publications. Information contained in ForwardHealth publications is used by DHS to resolve disputes regarding covered benefits that cannot be handled internally by HMOs or PIHPs. If there is a conflict, the HMO or PIHP contract prevails. If the contract does not specifically address a situation, Wisconsin Administrative Code ultimately prevails. HMO and PIHP contracts are available on the Acute and Primary Managed Care page (click the HMO Providers link, then the Resources and Help tab) for HMOs and on the Children's Specialty Programs page of the ForwardHealth Portal (click the Children's Specialty Managed Care Plans link, then the Policy tab) for PIHPs.

Topic #403

Managed Long-Term Care Programs

Wisconsin Medicaid has several MLTC (managed long-term care) programs that provide services to individuals who are elderly and/or who have disabilities. These members may be eligible to enroll in voluntary regional managed care programs such as Family Care, PACE (Program of All-Inclusive Care for the Elderly), and the Family Care Partnership Program. Additional information about these MLTC programs may be obtained from the Managed Care Organization area of the ForwardHealth Portal.

Topic #404

SSI HMO Program

Medicaid SSI HMOs provide the same benefits as Medicaid fee-for-service (for example, medical, dental [in certain counties only], mental health/substance abuse, and vision) at no cost to their members through a care management model. Medicaid SSI members and SSI-related Medicaid members may be eligible to enroll in an SSI HMO.

SSI-related Medicaid members receive coverage from Wisconsin Medicaid because of a disability determined by the Disability Determination Bureau.

Member Enrollment

Certain eligible SSI members and SSI-related Medicaid adult members are required to enroll in an SSI HMO. The following groups are excluded from the requirement to enroll in an SSI HMO:

- Members under 19 years of age
- Members of a federally recognized tribe
- Dual eligible members
- MAPP (Medicaid Purchase Plan) eligible members
- Members enrolled in a LTC (long-term care) MCO (managed care organization) or waiver program

Continuity of Care

Special provisions are included in the contract for SSI HMOs for continuity of care for SSI members and SSI-related Medicaid members. These provisions include the following:

- Coverage of services provided by the member's current provider for the first 90 days of enrollment in the SSI program or until the first of the month following completion of an assessment and care plan, whichever comes later. The contracted provider should get a referral from the member's HMO after this.
- Honoring a PA (prior authorization) that is currently approved by ForwardHealth. The PA must be honored for 90 days or until the month following the HMO's completion of the assessment and care plan, whichever comes later.

To assure payment, non-contracted providers should contact the SSI HMO to confirm claim submission and reimbursement processes. If an SSI HMO is not honoring a PA that is currently approved by ForwardHealth, the provider should first contact the HMO. If the provider is not able to resolve their issue with the HMO, the provider should contact ForwardHealth Provider Services.

For new authorizations during the member's first 90 days of enrollment, the provider is required to follow the SSI HMO's PA process. SSI HMOs may use PA guidelines that differ from fee-for-service guidelines; however, these guidelines may not result in less coverage than fee-for-service.

Care Management

SSI HMO health plans employ a care management model to ensure high-quality care to members. The care management model provides each enrollee with the following:

- An initial health assessment
- A comprehensive care plan
- Assistance in choosing providers and identifying a primary care provider
- Assistance in accessing social and community services
- Information about health education programs, treatment options, and follow-up procedures
- Advocates on staff to assist members in choosing providers and accessing needed care

ForwardHealth requires all SSI HMO health plans to have dedicated care managers to assist providers in meeting the medical care needs of members. SSI HMOs, through their care management teams, will serve as single points of contact for providers who need assistance addressing the health care needs of members, especially those who have multiple points of contact within the health care system.

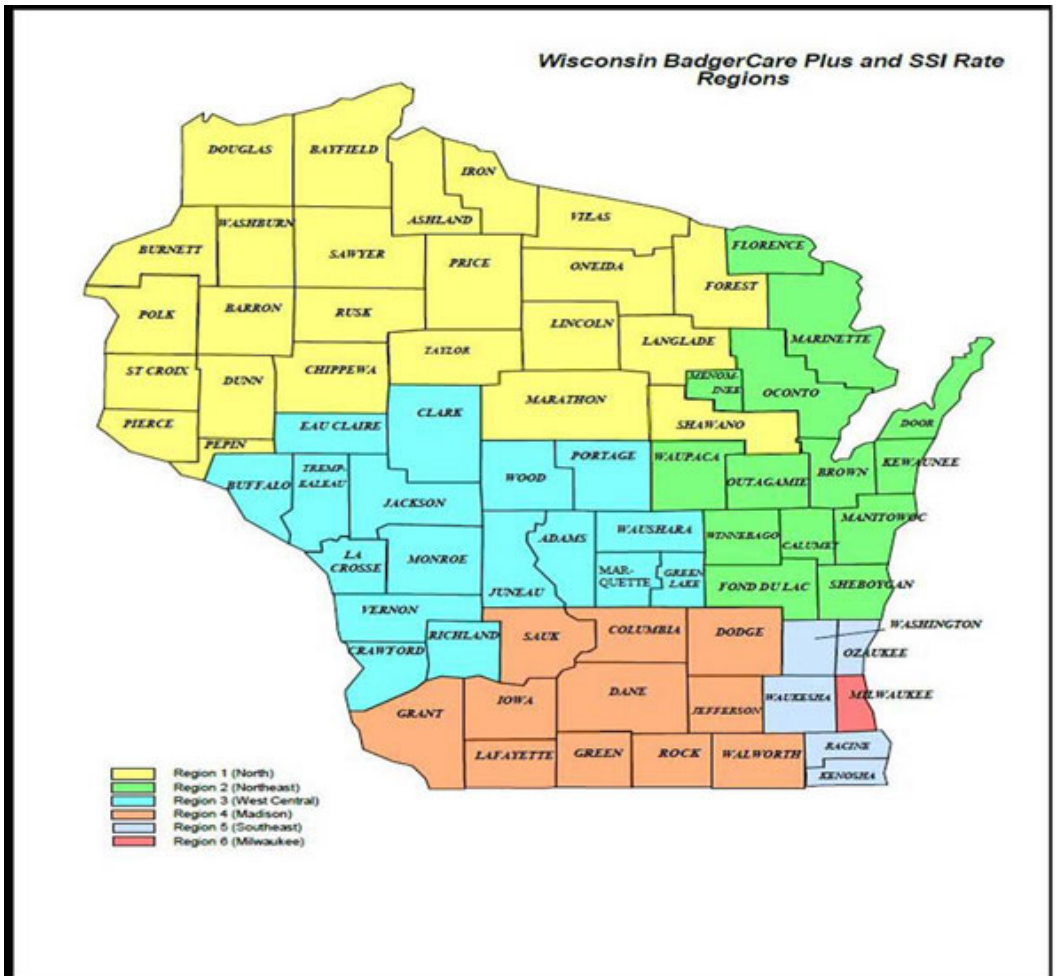
The SSI HMO care management teams will be responsible, when it is deemed appropriate, for notifying primary care providers of members' emergency room visits, hospital discharges, and other major medical events, as well as sharing patient-specific care management plans with appropriate providers to reduce hospital admissions and readmission, to reduce appointment no-shows, and to improve compliance with health care recommendations such as medication regimens.

Topic #20697

SSI Rate Regions

The map below shows the Wisconsin BadgerCare Plus and SSI (Supplemental Security Income) Rate Regions for the SSI HMO Program.

SSI Rate Regions


Wisconsin BadgerCare Plus and SSI Rate Regions
DOUGLAS
BAYFIELD
IRON
ASHLAND
VILAS
WASHBURN
BURNETT
SAWYER
PRICE
ONEIDA
FLORENCE
FOREST
POLK
BARRON
RUSK
LINCOLN
LANGLADE
MARINETTE
ST CROIX
DUNN
CHIPPEWA
TAYLOR
MENOM-INEE
OCONTO
PIERCE
EAU CLAIRE
CLARK
MARATHON
SHAWANO
DOOR
PEPIN
TREMP-EALEAU
WOOD
PORTAGE
WAUPACA
OUTAGAMIE
BROWN
KEWAUNEE
BUFFALO
JACKSON
WAUSHARA
WINNEBAGO
CALUMET
MANITOWOC
LA CROSSE
MONROE
ADAMS
MAR-QUETTE
GREEN LAKE
FOND DU LAC
SHEBOYGAN
JUNEAU
VERNON
RICHLAND
SAUK
COLUMBIA
DODGE
WASHINGTON
CRAWFORD
OZAUKEE
GRANT
IOWA
DANE
JEFFERSON
WAUKESHA
MILWAUKEE
LAFAYETTE
GREEN
ROCK
WALWORTH
RACINE
KENOSHA
Region 1 (North)
Region 2 (Northeast)
Region 3 (West Central)
Region 4 (Madison)
Region 5 (Southeast)
Region 6 (Milwaukee)

Prior Authorization

Topic #400

Prior Authorization Procedures

BadgerCare Plus HMOs and Medicaid SSI HMOs may develop PA (prior authorization) guidelines that differ from fee-for-service guidelines. However, the application of such guidelines may not result in less coverage than fee-for-service. Contact the enrollee's HMO or SSI HMO for more information regarding PA procedures.

Provider Information

Topic #406

Copays

Providers cannot charge Medicaid SSI HMO enrollees copays for covered services except in cases where the Medicaid SSI HMO does not cover services such as dental, chiropractic, and pharmacy. However, even in these cases, providers are prohibited from collecting copay from members who are exempt from the copay requirement.

When services are provided through fee-for-service or to members enrolled in a BadgerCare Plus HMO, copays will apply, except when the member or the service is exempt from the copay requirement.

Topic #407

Emergencies

Non-network providers may provide services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees in an emergency without authorization or in urgent situations when authorized by the HMO or SSI HMO. The contract between Wisconsin DHS (Department of Health Services) and the HMO or SSI HMO defines an emergency situation and includes general payment requirements.

Unless the HMO or SSI HMO has a written agreement with the non-network provider, the HMO or SSI HMO is only liable to the extent fee-for-service would be liable for an emergency situation, as defined in 42 C.F.R. § 438.114. Billing procedures for emergencies may vary depending on the HMO or SSI HMO. For specific billing instructions, non-network providers should always contact the enrollee's HMO or SSI HMO.

Topic #408

Non-Network Providers

Providers who do not have a contract with the enrollee's BadgerCare Plus HMO or Medicaid SSI HMO are referred to as non-network providers. (HMO and SSI HMO network providers agree to payment amounts and billing procedures in a contract with the HMO or SSI HMO.) Non-network providers are required to direct enrollees to HMO or SSI HMO network providers except in the following situations:

- When a non-network provider is treating an HMO or SSI HMO enrollee for an emergency medical condition as defined in the contract between the Wisconsin DHS (Department of Health Services) and the HMO or SSI HMO
- When the HMO or SSI HMO has authorized (in writing) an out-of-plan referral to a non-network provider
- When the service is not provided under the HMO's or SSI HMO's contract with the DHS (such as dental, chiropractic, and pharmacy services)

Non-network providers may not serve BadgerCare Plus HMO or Medicaid SSI HMO enrollees as private-pay patients.

Topic #409

Out-of-Area Care

BadgerCare Plus HMOs and Medicaid SSI HMOs may cover medically necessary care provided to enrollees when they travel outside the HMO's or SSI HMO's service area. The HMO or SSI HMO is required to authorize the services before the services are provided, except in cases of emergency. If the HMO or SSI HMO does not authorize the services, the enrollee may be held responsible for the cost of those services.

Topic #410

Provider Participation

Providers interested in participating in a BadgerCare Plus HMO or Medicaid SSI HMO or changing HMO or SSI HMO network affiliations should contact the HMO or SSI HMO for more information. Conditions and terms of participation in an HMO or SSI HMO are pursuant to specific contract agreements between HMOs or SSI HMOs and providers. An HMO or SSI HMO has the right to choose whether or not to contract with any provider but must provide access to Medicaid-covered, medically necessary services under the scope of their contract for enrolled members. Each HMO may have policies and procedures specific to their provider credentialing and contracting process that providers are required to meet prior to becoming an in-network provider for that HMO.

Topic #411

Referrals

Non-network providers may at times provide services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees on a referral basis. Non-network providers are always required to contact the enrollee's HMO or SSI HMO. Before services are provided, the non-network provider and the HMO or SSI HMO should discuss and agree upon billing procedures and fees for all referrals. Non-network providers and HMOs or SSI HMOs should document the details of any referral in writing before services are provided.

Billing procedures for out-of-plan referrals may vary depending on the HMO or SSI HMO. For specific billing instructions, non-network providers should always contact the enrollee's HMO or SSI HMO.

Topic #412

Services Not Provided by HMOs or SSI HMOs

If an enrollee's BadgerCare Plus HMO or Medicaid SSI HMO benefit package does not include a covered service, such as chiropractic or dental services, any Medicaid-enrolled provider may provide the service to the enrollee and submit claims to fee-for-service.

Member Information

5

Archive Date:10/01/2026

Member Information:Enrollment Categories

Topic #225

BadgerCare Plus

Populations Eligible for BadgerCare Plus

The following populations are eligible for BadgerCare Plus:

- Parents and caretakers with incomes at or below 100% of the FPL (Federal Poverty Level).
- Pregnant women with incomes at or below 300% of the FPL.
- Children (ages 18 and younger) with household incomes at or below 300% of the FPL.
- Childless adults with incomes at or below 100% of the FPL.
- Transitional medical assistance individuals, also known as members on extensions, with incomes over 100% of the FPL.

Where available, BadgerCare Plus members are enrolled in BadgerCare Plus HMOs. In those areas of Wisconsin where HMOs are not available, services will be reimbursed on a fee-for-service basis.

Premiums

The following members are required to pay premiums to be enrolled in BadgerCare Plus:

- Transitional medical assistance individuals with incomes over 133% of the FPL. Transitional medical assistance individuals with incomes between 100 and 133% FPL are exempt from premiums for the first six months of their eligibility period.
- Children (ages 18 and younger) with household incomes greater than 200% with the following exceptions:
  - Children under age 1 year.
  - Children who are tribal members or otherwise eligible to receive Indian Health Services.

Topic #16677

BadgerCare Plus Benefit Plan Changes

Effective April 1, 2014, all members eligible for BadgerCare Plus were enrolled in the BadgerCare Plus Standard Plan. As a result of this change, the following benefit plans were discontinued:

- BadgerCare Plus Benchmark Plan
- BadgerCare Plus Core Plan
- BadgerCare Plus Basic Plan

Members who are enrolled in the Benchmark Plan or the Core Plan who met new income limits for BadgerCare Plus eligibility were automatically transitioned into the BadgerCare Plus Standard Plan on April 1, 2014. In addition, the last day of BadgerRx Gold program coverage for all existing members was March 31, 2014.

Providers should refer to the March 2014 Online Handbook archive of the appropriate service area for policy information pertaining to these discontinued benefit plans.

Topic #785

BadgerCare Plus Prenatal Program

As a result of 2005 Wisconsin Act 25, BadgerCare has expanded coverage to the following individuals:

- Pregnant non-U.S. citizens who are not qualified aliens but meet other eligibility criteria for BadgerCare.
- Pregnant individuals detained by legal process who meet other eligibility criteria for BadgerCare.

The BadgerCare Plus Prenatal Program is designed to provide better birth outcomes.

Women are eligible for all covered services from the first of the month in which their pregnancy is verified or the first of the month in which the application for BadgerCare Plus is filed, whichever is later. Members are enrolled through the last day of the month in which they deliver or the pregnancy ends. Postpartum care is reimbursable **only** if provided as part of global obstetric care. Even though enrollment is based on pregnancy, these women are eligible for **all** covered services. (They are not limited to pregnancy-related services.)

These women are not presumptively eligible. Providers should refer them to the appropriate income maintenance or tribal agency where they can apply for this coverage.

Fee for Service

Pregnant non-U.S. citizens who are not qualified aliens and pregnant individuals detained by legal process receive care only on a fee-for-service basis. Providers are required to follow all program requirements (for example, claim submission procedures, PA (prior authorization) requirements) when providing services to these women.

Emergency Services for Non-U.S. Citizens

When BadgerCare Plus enrollment ends for pregnant non-U.S. citizens who are not qualified aliens, they receive coverage for emergency services. These women receive emergency coverage for 60 days after the pregnancy ends; this coverage continues through the end of the month in which the 60th day falls (for example, a woman who delivers on June 20, 2006, would be enrolled through the end of August 2006).

Topic #2757

Birth to 3 Program

A child from birth up to (but not including) age three is eligible for Birth to 3 services if the child meets one of the following criteria:

- The individual has a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.
- The individual has at least a 25% 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
- Atypical development affecting the child's overall development, as determined by a qualified team using professionally acceptable procedures and informed clinical opinion.

ForwardHealth provides Birth to 3 information because many children enrolled in the Birth to 3 Program are also BadgerCare Plus/Medicaid members.

There are certain referral requirements for therapy providers to encourage service coordination with the Birth to 3 Program.

Topic #230

Express Enrollment for Children and Pregnant Women

The EE (Express Enrollment) for Pregnant Women Benefit is a limited benefit category that allows a pregnant woman to receive immediate pregnancy-related outpatient services while her application for full-benefit BadgerCare Plus is processed. Enrollment is not restricted based on the member's other health insurance coverage. Therefore, a pregnant woman who has other health insurance may be enrolled in the benefit.

The EE for Children Benefit allows certain members through 18 years of age to receive BadgerCare Plus benefits while an application for BadgerCare Plus is processed.

Fee-for-Service

Women and children who are temporarily enrolled in BadgerCare Plus through the EE process are not eligible for enrollment in an HMO until they are determined eligible for full benefit BadgerCare Plus by the income maintenance or tribal agency.

Topic #226

Family Planning Only Services

Family Planning Only Services is a limited benefit program that provides routine contraceptive management or related services to low-income individuals who are of childbearing/reproductive age (typically 15 years of age or older) and who are otherwise not eligible for Wisconsin Medicaid or BadgerCare Plus. Members receiving Family Planning Only Services must be receiving routine contraceptive management or related services.

Note: Members who meet the enrollment criteria may receive routine contraceptive management or related services **immediately** by temporarily enrolling in Family Planning Only Services through EE (Express Enrollment).

The goal of Family Planning Only Services is to provide members with information and services to assist them in preventing pregnancy, making BadgerCare Plus enrollment due to pregnancy less likely. Providers should explain the purpose of Family Planning Only Services to members and encourage them to contact their certifying agency to determine their enrollment options if they are not interested in, or do not need, contraceptive services.

Members enrolled in Family Planning Only Services receive routine services to prevent or delay pregnancy and are not eligible for other services (for example, PT (physical therapy) services, dental services). Even if a medical condition is discovered during a family planning visit, treatment for the condition is not covered under Family Planning Only Services unless the treatment is identified in the list of allowable procedure codes for Family Planning Only Services.

Members are also not eligible for certain other services that are covered under Wisconsin Medicaid and BadgerCare Plus (for example, mammograms and hysterectomies). If a medical condition, other than an STD (sexually transmitted disease), is discovered during routine contraceptive management or related services, treatment for the medical condition is not covered under Family Planning Only Services.

Colposcopies and treatment for STDs are only covered through Family Planning Only Services if they are determined medically necessary during routine contraceptive management or related services. A colposcopy is a covered service when an abnormal result is received from a pap test, prior to the colposcopy, while the member is enrolled in Family Planning Only Services and receiving contraceptive management or related services.

Family Planning Only Services members diagnosed with cervical cancer, precancerous conditions of the cervix, or breast cancer may be eligible for Wisconsin Well Woman Medicaid. Providers should assist eligible members with the enrollment process for Well Woman Medicaid.

Providers should inform members about other coverage options and provide referrals for care not covered by Family Planning Only Services.

Topic #4757

ForwardHealth and ForwardHealth interChange

ForwardHealth brings together many Wisconsin DHS (Department of Health Services) health care programs with the goal to create efficiencies for providers and to improve health outcomes for members. ForwardHealth interChange is the DHS claims processing system that supports multiple state health care programs and web services, including:

- BadgerCare Plus
- BadgerCare Plus and Medicaid managed care programs
- SeniorCare
- HDAP (Wisconsin HIV Drug Assistance Program)
- WCDP (Wisconsin Chronic Disease Program)
- WIR (Wisconsin Immunization Registry)
- Wisconsin Medicaid
- Wisconsin Well Woman Medicaid
- WWWP (Wisconsin Well Woman Program)

ForwardHealth interChange is supported by the state's fiscal agent, Gainwell Technologies.

Topic #229

Limited Benefit Categories Overview

Certain members may be enrolled in a limited benefit category. These limited benefit categories include the following:

- BadgerCare Plus Prenatal Program
- EE (Express Enrollment) for Children
- EE for Pregnant Women
- Family Planning Only Services, including EE for individuals applying for Family Planning Only Services
- QDWI (Qualified Disabled Working Individuals)
- QI-1 (Qualifying Individuals 1)
- QMB Only (Qualified Medicare Beneficiary Only)
- SLMB (Specified Low-Income Medicare Beneficiary)
- Tuberculosis-Related Medicaid

Members may be enrolled in full-benefit Medicaid or BadgerCare Plus and also be enrolled in certain limited benefit programs, including QDWI, QI-1, QMB Only, and SLMB. In those cases, a member has full Medicaid or BadgerCare Plus coverage in addition to limited coverage for Medicare expenses.

Members enrolled in the BadgerCare Plus Prenatal Program, Family Planning Only Services, EE for Children, EE for Pregnant Women, or Tuberculosis-Related Medicaid cannot be enrolled in full-benefit Medicaid or BadgerCare Plus. These members receive benefits through the limited benefit category.

Providers should note that a member may be enrolled in more than one limited benefit category. For example, a member may be enrolled in Family Planning Only Services and Tuberculosis-Related Medicaid.

Providers are strongly encouraged to verify dates of enrollment and other coverage information using Wisconsin's EVS (Enrollment Verification System) to determine whether a member is in a limited benefit category, receives full-benefit Medicaid or BadgerCare Plus, or both.

Providers are responsible for knowing which services are covered under a limited benefit category. If a member of a limited benefit category requests a service that is not covered under the limited benefit category, the provider may collect payment from the member if certain conditions are met.

Topic #228

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for selected groups of people who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP (Wisconsin Medical Assistance Program), MA (Medical Assistance), Title XIX, or T19.

A Medicaid member is any individual entitled to benefits under Title XIX of the Social Security Act and under the Medical Assistance State Plan as defined in Wis. Stat. ch. 49.

Wisconsin Medicaid enrollment is determined on the basis of financial need and other factors. A citizen of the United States or a "qualified immigrant" who meets low-income financial requirements may be enrolled in Wisconsin Medicaid if they are in one of the following categories:

- Age 65 and older
- Blind
- Disabled

Some needy and low-income people become eligible for Wisconsin Medicaid by qualifying for programs such as:

- Katie Beckett
- Medicaid Purchase Plan
- Foster care or adoption assistance programs
- SSI (Supplemental Security Income)
- WWWP (Wisconsin Well Woman Program)

Providers may advise these individuals or their representatives to contact their certifying agency for more information. The following agencies certify people for Wisconsin Medicaid enrollment:

- Income maintenance or tribal agencies
- Medicaid outstation sites
- SSA (Social Security Administration) offices

In limited circumstances, some state agencies also certify individuals for Wisconsin Medicaid.

Medicaid fee-for-service members receive services through the traditional health care payment system under which providers receive a payment for each unit of service provided. Some Medicaid members receive services through state-contracted MCOs

(managed care organizations).

Topic #232

Qualified Disabled Working Individual Members

QDWI (Qualified Disabled Working Individual) members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part A.

QDWI members are certified by their income maintenance or tribal agency. To qualify, QDWI members are required to meet the following qualifications:

- Have income under 200% of the FPL (Federal Poverty Level)
- Be entitled to, but not necessarily enrolled in, Medicare Part A
- Have income or assets too high to qualify for QMB-Only (Qualified Medicare Beneficiary-Only) and SLMB (Specified Low-Income Medicare Beneficiary)

Topic #234

Qualified Medicare Beneficiary-Only Members

QMB-Only (Qualified Medicare Beneficiary-Only) members are a limited benefit category of Medicaid members. They receive payment of the following:

- Medicare monthly premiums for Part A, Part B, or both
- Coinsurance, copay, and deductible for Medicare-allowed services

QMB-Only members are certified by their income maintenance or tribal agency. QMB-Only members are required to meet the following qualifications:

- Have an income under 100% of the FPL (Federal Poverty Level)
- Be entitled to, but not necessarily enrolled in, Medicare Part A

Topic #235

Qualifying Individual 1 Members

QI-1 (Qualifying Individual 1) members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part B.

QI-1 members are certified by their income maintenance or tribal agency. To qualify, QI-1 members are required to meet the following qualifications:

- Have income between 120 and 135% of the FPL (Federal Poverty Level)
- Be entitled to, but not necessarily enrolled in, Medicare Part A

Topic #18777

Real-Time Eligibility Determinations

ForwardHealth may complete real-time eligibility determinations for BadgerCare Plus and/or Family Planning Only Services applicants who meet pre-screening criteria and whose reported information can be verified in real time while applying in ACCESS Apply for Benefits. Once an applicant is determined eligible through the real-time eligibility process, they are considered eligible for BadgerCare Plus and/or Family Planning Only Services and will be enrolled for 12 months, unless changes affecting eligibility occur before the 12-month period ends.

A member determined eligible through the real-time eligibility process will receive a temporary ID (identification) card for BadgerCare Plus and/or Family Planning Only Services. Each member will get their own card, and each card will include the member's ForwardHealth ID number. The temporary ID card will be valid for the dates listed on the card and will allow the member to get immediate health care or pharmacy services.

Eligibility Verification

When a member is determined eligible for BadgerCare Plus and/or Family Planning Only Services through the real-time eligibility process, providers are able to see the member's eligibility information in Wisconsin's EVS (Enrollment Verification System) in real time. Providers should always verify eligibility through EVS prior to providing services.

On rare occasions, it may take up to 48 hours for eligibility information to be available through interChange. In such instances, if a member presents a valid temporary ID card, **the provider is still required to provide services**, even if eligibility cannot be verified through EVS.

Sample Temporary Identification Card for Badger Care Plus

To the Provider

The individual listed on this card has been enrolled in BadgerCare Plus. This card entitles the listed individual to receive health care services, including pharmacy services, through BadgerCare Plus from any Medicaid-enrolled provider. For additional information, call Provider Services at 800-947-9627 or refer to the ForwardHealth Online Handbook at *www.forwardhealth.wi.gov*.

NOTE:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services, as long as other reimbursement requirements are met. All policies regarding covered services apply for this individual, including the prohibition against billing members. If "Pending Assignment" is indicated after the name on this card, the member identification (ID) number will be assigned within one business day; the card is still valid. Refer to the ForwardHealth Online Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR BADGERCARE PLUS

Name:	Program	ID Number
IM A MEMBER DOB: 09/01/1984	BadgerCare Plus	0987654321

This card is valid from **October 01, 2016 to November 30, 2016.**

This individual's eligibility should be available through the ForwardHealth Portal. Eligibility should always be verified through the ForwardHealth Portal prior to services being provided.

SAMPLE

Sample Temporary Identification Card for Family Planning Only Services

To the Provider

The individual listed on this card has been enrolled in Family Planning Only Services. This card entitles the listed individual to receive health care services, including pharmacy services, through Family Planning Only Services from any Medicaid-enrolled provider. For additional information, call Provider Services at 800-947-9627 or refer to the ForwardHealth Online Handbook at *www.forwardhealth.wi.gov*.

NOTE:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services, as long as other reimbursement requirements are met. All policies regarding covered services apply for this individual, including the prohibition against billing members. If "Pending Assignment" is indicated after the name on this card, the member identification (ID) number will be assigned within one business day; the card is still valid. Refer to the ForwardHealth Online Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR FAMILY PLANNING ONLY SERVICES

Name:	Program	ID Number
IM A MEMBER DOB: 09/01/1984	Family Planning Only Services	0987654321

This card is valid from **October 01, 2016 to November 30, 2016.**

This individual's eligibility should be available through the ForwardHealth Portal. Eligibility should always be verified through the ForwardHealth Portal prior to services being provided.

SAMPLE

Topic #236

Specified Low-Income Medicare Beneficiaries

SLMB (Specified Low-Income Medicare Beneficiary) members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part B.

SLMB members are certified by their income maintenance or tribal agency. To qualify, SLMB members are required to meet the following qualifications:

- Have an income under 120% of the FPL (Federal Poverty Level)
- Be entitled to, but not necessarily enrolled in, Medicare Part A

Topic #262

Tuberculosis-Related Medicaid

Tuberculosis-Related Medicaid is a limited benefit category that allows individuals with TB (tuberculosis) infection or disease to receive covered TB-related outpatient services.

Topic #240

Wisconsin Well Woman Medicaid

Wisconsin Well Woman Medicaid provides full Medicaid benefits to underinsured or uninsured women ages 35 to 64 who have

been screened and diagnosed by WWWP (Wisconsin Well Woman Program) or Family Planning Only Services, meet all other enrollment requirements, and are in need of treatment for any of the following:

- Breast cancer
- Cervical cancer
- Precancerous conditions of the cervix

Services provided to women who are enrolled in WWWMA (Wisconsin Well Woman Medicaid) are reimbursed through Medicaid fee-for-service.

Enrollment Responsibilities

Topic #241

General Information

Members have certain responsibilities per Wis. Admin. Code § DHS 104.02 and the ForwardHealth Enrollment and Benefits (P-00079 (07/14)) booklet.

Topic #243

Loss of Enrollment — Financial Liability

Some covered services consist of a series of sequential treatment steps, meaning more than one office visit is required to complete treatment.

In most cases, if a member loses enrollment midway through treatment, BadgerCare Plus and Medicaid will **not** reimburse services (including prior authorized services) after enrollment has lapsed.

Members are financially responsible for any services received after their enrollment has been terminated. If the member wishes to continue treatment, it is a decision between the provider and the member whether the service should be given and how the services will be paid. The provider may collect payment from the member if the member accepts responsibility for payment of a service and certain conditions are met.

To avoid misunderstandings, it is recommended that providers remind members that they are financially responsible for any continued care after enrollment ends.

To avoid potential reimbursement problems that can arise when a member loses enrollment midway through treatment, the provider is encouraged to verify the member's enrollment using the EVS (Enrollment Verification System) or the ForwardHealth Portal prior to providing each service, even if an approved PA (prior authorization) request is obtained for the service.

Topic #707

Member Cooperation

Members are responsible for giving providers full and accurate information necessary for the correct submission of claims. If a member has other health insurance, it is the member's obligation to give full and accurate information to providers regarding the insurance.

Topic #269

Members Should Present Card

It is important that providers determine a member's enrollment and other insurance coverage **prior to** each DOS (date of service) that services are provided. Pursuant to Wis. Admin. Code § DHS 104.02(2), a member should inform providers that they are enrolled in BadgerCare Plus or Wisconsin Medicaid and should present a current ForwardHealth identification card before

receiving services.

Note: Due to the nature of their specialty, certain providers — such as anesthesiologists, radiologists, DME (durable medical equipment) suppliers, independent laboratories, and ambulances — are not always able to see a member's ForwardHealth identification card because they might not have direct contact with the member prior to providing the service. In these circumstances, it is still the provider's responsibility to obtain member enrollment information.

Topic #244

Prior Identification of Enrollment

Except in emergencies that preclude prior identification, members are required to inform providers that they are receiving benefits and must present their ForwardHealth identification card before receiving care. If a member forgets their ForwardHealth card, providers may verify enrollment without it.

Topic #245

Reporting Changes to Caseworkers

Members are required to report certain changes to their caseworker at their certifying agency. These changes include, but are not limited to, the following:

- A new address or a move out of state
- A change in income
- A change in family size, including pregnancy
- A change in other health insurance coverage
- Employment status
- A change in assets for members who are over 65 years of age, blind, or disabled

Enrollment Rights

Topic #246

Appealing Enrollment Determinations

Applicants and members have the right to appeal certain decisions relating to BadgerCare Plus, Medicaid, or HDAP (Wisconsin HIV Drug Assistance Program) enrollment. An applicant, a member, or authorized person acting on behalf of the applicant or member, or former member may file the appeal with the DHA (Division of Hearings and Appeals).

Pursuant to Wis. Admin. Code § HA 3.03, an applicant, member, or former member may appeal any adverse action or decision by an agency or department that affects their benefits. Examples of decisions that may be appealed include, but are not limited to, the following:

- Individual was denied the right to apply.
- Application for BadgerCare Plus, HDAP, or Wisconsin Medicaid was denied.
- Application for BadgerCare Plus, HDAP, or Wisconsin Medicaid was not acted upon promptly.
- Enrollment was unfairly discontinued, terminated, suspended, or reduced.

In the case when enrollment is cancelled or terminated, the date the member, or authorized person acting on behalf of the member, files an appeal with the DHA determines what continuing coverage, if any, the member will receive until the hearing decision is made. The following scenarios describe the coverage allowed for a member who files an appeal:

- If a member files an appeal before his or her enrollment ends, coverage will continue pending the hearing decision.
- If a member files an appeal within 45 days after his or her enrollment ends, a hearing is allowed but coverage is not reinstated.

If the member files an appeal more than 45 days after his or her enrollment ends, a hearing is not allowed. Members may file an appeal by submitting a Request for Fair Hearing (DHA-28 (08/09)) form.

Claims for Appeal Reversals

Claim Denial Due to Termination of BadgerCare Plus or Wisconsin Medicaid Enrollment

If a claim is denied due to termination of BadgerCare Plus or Wisconsin Medicaid enrollment, a hearing decision that reverses that determination will allow the claim to be resubmitted and paid. The provider is required to obtain a copy of the appeal decision from the member, attach the copy to the previously denied claim, and submit both to ForwardHealth at the following address:

ForwardHealth
Specialized Research
Ste 50
313 Blettner Blvd
Madison WI 53784

If a provider has not yet submitted a claim, the provider is required to submit a copy of the hearing decision along with a paper claim to Specialized Research.

As a reminder, claims submission deadlines still apply even to those claims with hearing decisions.

Claim Denial Due to Termination of HDAP Enrollment

If a claim is denied due to termination of HDAP 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
HDAP Claims and Adjustments
PO Box 8758
Madison WI 53708

If a provider has not yet submitted a claim, the provider is required to submit a copy of the hearing decision along with a paper claim to HDAP Claims and Adjustments.

As a reminder, claims submission deadlines still apply even to those claims with hearing decisions.

Topic #247

Freedom of Choice

Members may receive covered services from **any** willing Medicaid-enrolled provider, unless they are enrolled in a state-contracted MCO (managed care organization) or assigned to the Pharmacy Services Lock-In Program.

Topic #248

General Information

Members are entitled to certain rights per Wis. Admin. Code ch. DHS 103.

Topic #250

Notification of Discontinued Benefits

When DHS (Department of Health Services) intends to discontinue, suspend, or reduce a member's benefits, or reduce or eliminate coverage of services for a general class of members, DHS sends a written notice to members. This notice is required to be provided at least 10 days before the effective date of the action.

Topic #252

Prompt Decisions on Enrollment

Individuals applying for BadgerCare Plus or Wisconsin Medicaid have the right to prompt decisions on their applications. Enrollment decisions are made within 60 days of the date the application was signed for those with disabilities and within 30 days for all other applicants.

Topic #254

Requesting Retroactive Enrollment

An applicant has the right to request retroactive enrollment when applying for BadgerCare Plus or Wisconsin Medicaid. Enrollment may be backdated to the first of the month three months prior to the date of application for eligible members. Retroactive enrollment does not apply to QMB-Only (Qualified Medicare Beneficiary-Only) members.

Identification Cards

Topic #266

ForwardHealth Identification Cards

Each enrolled member receives an identification card. Possession of a program identification card does not guarantee enrollment. It is possible that a member will present a card during a lapse in enrollment; therefore, it is essential that providers verify enrollment before providing services. Members are told to keep their cards even though they may have lapses in enrollment.

ForwardHealth Identification Card Features

The ForwardHealth identification card includes the member's name, 10-digit member ID, magnetic stripe, signature panel, and the Member Services telephone number. The card also has a unique, 16-digit card number on the front for internal program use.

The ForwardHealth card does not need to be signed to be valid; however, adult members are encouraged to sign their cards. Providers may use the signature as another means of identification.

The toll-free number on the back of each of the cards is for member use only. The address on the back of each card is used to return a lost card to ForwardHealth if it is found.

If a provider finds discrepancies with the identification number or name between what is indicated on the ForwardHealth card and the provider's file, the provider should verify enrollment with Wisconsin's EVS (Enrollment Verification System).

Digital ForwardHealth Identification Cards

Members can access digital versions of their ForwardHealth cards on the MyACCESS mobile app. Members are able to save PDFs and print out paper copies of their cards from the app. The digital and paper printout versions of the cards are identical to the physical cards for the purposes of accessing Medicaid-covered services. All policies that apply to the physical cards mailed by ForwardHealth to the member also apply to the digital or printed versions that members may present.

A member may still access their digital ForwardHealth card on the MyACCESS app when they are no longer enrolled. The MyACCESS app will display a banner message noting that the member is not currently enrolled in a ForwardHealth program. Providers should always verify enrollment with Wisconsin's EVS.

Identification Number Changes

Some providers may question whether services should be provided if a member's 10-digit identification number on their ForwardHealth card does not match the EVS response. If the EVS indicates the member is enrolled, services should be provided.

A member's identification number may change, and the EVS will reflect that change. However, ForwardHealth does not automatically send a replacement ForwardHealth card with the new identification number to the member. ForwardHealth cross-references the old and new identification numbers so a provider may submit claims with either number. The member may request a replacement ForwardHealth card that indicates the new number.

Member Name Changes

If a member's name on the ForwardHealth card is different than the response given from Wisconsin's EVS, providers should use

the name from the EVS response. When a name change is reported and on file, a new card will automatically be sent to the member.

Deactivated Cards

When any member identification card has been replaced for any reason, the previous identification card is deactivated. If a member presents a deactivated card, providers should encourage the member to discard the deactivated card and use only the new card.

Although a member identification card may be deactivated, the member ID is valid and the member still may be enrolled in a ForwardHealth program.

If a provider swipes a ForwardHealth card using a magnetic stripe card reader and finds that it has been deactivated, the provider may request a second form of identification if they do not know the member. After the member's identity has been verified, providers may verify a member's enrollment by using one of the EVS methods such as AVR (Automated Voice Response).

Defective Cards

If a provider uses a card reader for a ForwardHealth card and the magnetic stripe is defective, the provider should encourage the member to call Member Services at the number listed on the back of the member's card to request a new card.

If a member presents a ForwardHealth card with a defective magnetic stripe, providers may verify the member's enrollment by using an alternate enrollment verification method. Providers may also verify a member's enrollment by entering the member ID or 16-digit card number on a touch pad, if available, or by calling WiCall or Provider Services.

Lost Cards

If a member needs a replacement ForwardHealth card, they may call Member Services to request a new one.

If a member lost their ForwardHealth card or never received one, the member may call Member Services to request a new one.

Managed Care Organization Enrollment Changes

Members do not receive a new ForwardHealth card if they are enrolled in a state-contracted MCO (managed care organization) or change from one MCO to another. Providers should verify enrollment with the EVS every time they see a member to ensure they have the most current managed care enrollment information.

Topic #1435

Types of Identification Cards

ForwardHealth members receive an identification card upon initial eligibility determination. Identification cards may be presented in different formats (for example, white plastic cards, paper cards, or paper printouts), depending on the program and the method used to enroll (for example, paper application or online application). Members who are temporarily enrolled in BadgerCare Plus or Family Planning Only Services receive temporary identification cards.

Misuse and Abuse of Benefits

Topic #271

Examples of Member Abuse or Misuse

Examples of member abuse or misuse are included in Wis. Admin. Code § DHS 104.02(5).

Topic #274

Pharmacy Services Lock-In Program

Overview of the Pharmacy Services Lock-In Program

The purpose of the Pharmacy Services Lock-In Program is to coordinate the provision of health care services for members who abuse or misuse Medicaid, BadgerCare Plus, or SeniorCare benefits by seeking duplicate or medically unnecessary services, particularly for controlled substances. The Pharmacy Services Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in Wis. Admin. Code § DHS 104.02.

Coordination of member health care services is intended to:

- Curb the abuse or misuse of controlled substance medications.
- Improve the quality of care for a member.
- Reduce unnecessary physician utilization.

The Pharmacy Services Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in Wis. Admin. Code § DHS 104.02. The abuse and misuse definition includes:

- Not duplicating or altering prescriptions
- Not feigning illness, using false pretense, providing incorrect enrollment status, or providing false information to obtain service
- Not seeking duplicate care from more than one provider for the same or similar condition
- Not seeking medical care that is excessive or not medically necessary

The Pharmacy Services Lock-In Program applies to members in fee-for-service as well as members enrolled in Medicaid SSI HMOs and BadgerCare Plus HMOs. Members remain enrolled in the Pharmacy Services Lock-In Program for two years and are continuously monitored for their prescription drug usage. At the end of the two-year enrollment period, an assessment is made to determine if the member should continue enrollment in the Pharmacy Services Lock-In Program.

Members enrolled in the Pharmacy Services Lock-In Program will be locked into one pharmacy where prescriptions for restricted medications must be filled and one prescriber who will prescribe restricted medications. Restricted medications are most controlled substances, carisoprodol, and tramadol. Referrals will be required only for restricted medication services.

Fee-for-service members enrolled in the Pharmacy Services Lock-In Program may choose physicians and pharmacy providers from whom to receive prescriptions and medical services not related to restricted medications. Members enrolled in an HMO must comply with the HMO's policies regarding care that is not related to restricted medications.

Referrals of members as candidates for lock-in are received from retrospective DUR (Drug Utilization Review), physicians, pharmacists, other providers, and through automated surveillance methods. Once a referral is received, six months of pharmacy claims and diagnoses data are reviewed. A recommendation for one of the following courses of action is then made:

- No further action.
- Send an intervention letter to the physician.
- Send a warning letter to the member.
- Enroll the member in the Pharmacy Services Lock-In Program.

Medicaid, BadgerCare Plus, and SeniorCare members who are candidates for enrollment in the Pharmacy Services Lock-In Program are sent a letter of intent, which explains the restriction that will be applied, how to designate a primary prescriber and a pharmacy, and how to request a hearing if they wish to contest the decision for enrollment (that is, due process). If a member fails to designate providers, the Pharmacy Services Lock-In Program may assign providers based on claims' history. In the letter of intent, members are also informed that access to emergency care is not restricted.

Letters of notification are sent to the member and to the lock-in primary prescriber and pharmacy. Providers may designate alternate prescribers or pharmacies for restricted medications, as appropriate. Members remain in the Pharmacy Services Lock-In Program for two years. The primary lock-in prescriber and pharmacy may make referrals for specialist care or for care that they are otherwise unable to provide (for example, home infusion services). The member's utilization of services is reviewed prior to release from the Pharmacy Services Lock-In Program, and lock-in providers are notified of the member's release date.

Excluded Drugs

The following scheduled drugs will be excluded from monitoring by the Pharmacy Services Lock-In Program:

- Anabolic steroids
- Barbiturates used for seizure control
- Lyrica
- Provigil and Nuvigil
- Weight loss drugs

Pharmacy Services Lock-In Program Administrator

The Pharmacy Services Lock-In Program is administered by Acentra. Acentra may be contacted by phone at 877-719-3123, by fax at 800-881-5573, or by mail at the following address:

Pharmacy Services Lock-In Program
c/o Acentra
PO Box 3570
Auburn AL 36831-3570

Pharmacy Services Lock-In Prescribers Are Required to Be Enrolled in Wisconsin Medicaid

To prescribe restricted medications for Pharmacy Services Lock-In Program members, prescribers are required to be enrolled in Wisconsin Medicaid. Enrollment for the Pharmacy Services Lock-In Program is not separate from enrollment in Wisconsin Medicaid.

Role of the Lock-In Prescriber and Pharmacy Provider

The lock-in prescriber determines what restricted medications are medically necessary for the member, prescribes those

medications using their professional discretion, and designates an alternate prescriber if needed. If the member requires an alternate prescriber to prescribe restricted medications, the primary prescriber should complete the Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services (F-11183 (02/2025)) form and return it to the Pharmacy Services Lock-In Program and to the member's HMO, if applicable.

To coordinate the provision of medications, the lock-in prescriber may also contact the lock-in pharmacy to give the pharmacist (s) guidelines as to which medications should be filled for the member and from whom. The primary lock-in prescriber should also coordinate the provision of medications with any other prescribers they have designated for the member.

The lock-in pharmacy fills prescriptions for restricted medications that have been written by the member's lock-in prescriber(s) and works with the lock-in prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The lock-in pharmacy may fill prescriptions for medications from prescribers other than the lock-in prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated lock-in prescriber, the claim will be denied.

Designated Lock-In Pharmacies

The Pharmacy Services Lock-In Program pharmacy fills prescriptions for restricted medications that have been written by the member's lock-in prescriber(s) and works with the lock-in prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The lock-in pharmacy may fill prescriptions for medications from prescribers other than the lock-in prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated lock-in prescriber, the claim will be denied.

Alternate Providers for Members Enrolled in the Pharmacy Services Lock-In Program

Members enrolled in the Pharmacy Services Lock-In Program do not have to visit their lock-in prescriber to receive medical services unless an HMO requires a primary care visit. Members may see other providers to receive medical services; however, other providers cannot prescribe restricted medications for Pharmacy Services Lock-In Program members unless specifically designated to do so by the primary lock-in prescriber. For example, if a member sees a cardiologist, the cardiologist may prescribe a statin for the member, but the cardiologist may not prescribe restricted medications unless they have been designated by the lock-in prescriber as an alternate provider.

A referral to an alternate provider for a Pharmacy Services Lock-In Program member is necessary only when the member needs to obtain a prescription for a restricted medication from a provider other than their lock-in prescriber or lock-in pharmacy.

If the member requires alternate prescribers to prescribe restricted medications, the primary lock-in prescriber is required to complete the Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services form. Referrals for fee-for-service members must be on file with the Pharmacy Services Lock-In Program. Referrals for HMO members must be on file with the Pharmacy Service Lock-In Program and the member's HMO.

Designated alternate prescribers are required to be enrolled in Wisconsin Medicaid.

Claims from Providers Who Are Not Designated Pharmacy Services Lock-In Providers

If the member brings a prescription for a restricted medication from a non-lock-in prescriber to the designated lock-in pharmacy, the pharmacy provider cannot fill the prescription.

If a pharmacy claim for a restricted medication is submitted from a provider who is not the designated lock-in prescriber, alternate prescriber, lock-in pharmacy, or alternate pharmacy, the claim will be denied. If a claim is denied because the prescription is not

from a designated lock-in prescriber, the lock-in pharmacy provider cannot dispense the drug or collect a cash payment from the member because the service is a nonreimbursable service. However, the lock-in pharmacy provider may contact the lock-in prescriber to request a new prescription for the drug, if appropriate.

To determine if a provider is on file with the Pharmacy Services Lock-In Program, the lock-in pharmacy provider may do one of the following:

- Speak to the member.
- Call Acentra.
- Call Provider Services.
- Use the ForwardHealth Portal.

Claims are not reimbursable if the designated lock-in prescriber, alternate lock-in prescriber, lock-in pharmacy, or alternate lock-in pharmacy provider is not on file with the Pharmacy Services Lock-In Program.

For More Information

Providers may call Acentra with questions about the Pharmacy Services Lock-In Program. Pharmacy providers may also refer to the list of restricted medications data table or call Provider Services with questions about the following:

- Drugs that are restricted for Pharmacy Services Lock-In Program members
- A member's enrollment in the Pharmacy Services Lock-In Program
- A member's designated lock-in prescriber or lock-in pharmacy

Topic #273

Providers May Refuse to Provide Services

Providers may refuse to provide services to a BadgerCare Plus or Medicaid member in situations when there is reason to believe that the person presenting the ForwardHealth identification card is misusing or abusing it.

Members who abuse or misuse BadgerCare Plus or Wisconsin Medicaid benefits or their ForwardHealth card may have their benefits terminated or be subject to limitations under the Pharmacy Services Lock-In Program or to criminal prosecution.

Topic #275

Requesting Additional Proof of Identity

Providers may request additional proof of identity from a member if they suspect fraudulent use of a ForwardHealth identification card. If another form of identification is not available, providers can compare a person's signature with the signature on the back of the ForwardHealth identification card if it is signed. (Adult members are encouraged to sign the back of their cards; however, it is not mandatory for members to do so.)

Verifying member identity, as well as enrollment, can help providers detect instances of fraudulent ForwardHealth card use.

Special Enrollment Circumstances

Topic #23277

12-Month Continuous Health Care Coverage for Children

Most children enrolled in BadgerCare Plus or Medicaid programs will keep their health insurance coverage for 12 months. Even if their family has a change in income or other circumstances, children under age 19 will have coverage at least until their next renewal. This policy is required by the federal Consolidated Appropriations Act, 2023.

Children enrolled in Foster Care Medicaid or SSI Medicaid will have 12-months of continuous coverage even if their out-of-home placement, subsidized guardianship, court-ordered kinship care, adoption assistance agreement, or SSI payment ends.

Qualifying Programs

Members under age 19 in the following programs qualify for continuous coverage:

- BadgerCare Plus
- Emergency Services Medicaid
- Family Planning Only Services
- Foster Care Medicaid
- HCBW (Home and Community-Based Waiver) Medicaid
- Institutional Medicaid
- Katie Beckett Medicaid
- MAPP (Medicaid Purchase Plan)
- Medicare Savings Programs
- Special Status Medicaid
- SSI (Supplemental Security Income)-Related Medicaid
- SSI Medicaid
- Tuberculosis-Related Medicaid
- Wisconsin Well Woman Medicaid

Exceptions to Continuous Coverage

Continuous coverage does not apply to children:

- Enrolled under presumptive eligibility, also known as Express Enrollment.
- Enrolled by meeting a deductible. These are members who become eligible for up to a six-month period based on their medical expenses.

Children remain eligible for the 12 months until their next renewal unless:

- They turn 19.
- They move out of Wisconsin.
- Their citizenship or immigration status is not verified.
- Their eligibility was based on inaccurate information or agency error.
- The family asks to end their coverage.

Assisting Members Through Enrollment Renewals

Helping families through the health care renewal process remains vital to keeping children covered. Providers are asked to remind BadgerCare Plus and other Wisconsin Medicaid program members to renew their coverage, even if they think their situation will change in the future. Members should also be reminded to tell their agency about any changes to their address, phone number, or email to ensure they continue to receive important information about their health care coverage from Wisconsin DHS (Department of Health Services).

Member Resources

Free Health Insurance Application and Renewal Assistance

Members who need help with applying for or renewing health care coverage can access the following resources:

- Covering Wisconsin (free expert help with health insurance), available at the WisCovered website
- 211 Wisconsin at 211 or 877-947-2211

Continuous Coverage and Health Care Renewal Information

Additional member resources regarding health care renewals and continuous coverage for children are available:

- Medicaid: Programs for Children web page
- Health Care Renewals web page
- "Keeping Kids Covered" 12-Month Continuous Coverage for Children fact sheet
- BadgerCare Plus: Frequently Asked Questions

Additional policy information on continuous coverage for children is available in the BadgerCare Plus Handbook.

Topic #276

Medicaid Members From Other States

Wisconsin Medicaid does not pay for services provided to members enrolled in other state Medicaid programs. Providers are advised to contact other state Medicaid programs to determine whether the service sought is a covered service under that state's Medicaid program.

Topic #279

Members Traveling Out of State

When a member travels out of state but is within the United States (including its territories), Canada, or Mexico, BadgerCare Plus and Wisconsin Medicaid cover medical services in any of the following circumstances:

- An emergency illness or accident
- When the member's health would be endangered if treatment were postponed
- When the member's health would be endangered if travel to Wisconsin were undertaken
- When PA (prior authorization) has been granted to the provider for provision of a nonemergency service
- When there are coinsurance, copay, or deductible amounts remaining after Medicare payment or approval for dual eligibles

Travel expenses such as lodging or food are not reimbursable by Wisconsin Medicaid.

Note: Some providers located in a state that borders Wisconsin may be Wisconsin Medicaid enrolled as a border-status provider if the provider notifies ForwardHealth in writing that it is common practice for members in a particular area of Wisconsin to seek their medical services. Border-status providers follow the same policies as Wisconsin providers.

Topic #552

Newborn Reporting

Hospitals, physicians, nurse practitioners, nurse midwives, licensed midwives, and BadgerCare Plus or Medicaid HMOs may submit newborn reports to report babies born to mothers enrolled in BadgerCare Plus or Wisconsin Medicaid at the time of birth. Timely reporting of newborns ensures that there will be no delay in receiving important services.

Note: "Mother" refers to the person who gave birth to the newborn. Providers should only report newborns born to the mother who is enrolled in BadgerCare Plus or Wisconsin Medicaid.

Physicians, nurse practitioners, nurse midwives, and licensed midwives should report newborns **only** if the mother is **not** enrolled in a BadgerCare Plus HMO and the birth occurs outside a hospital setting. Otherwise, the hospital **or** BadgerCare Plus HMO should report the birth. If a mother is enrolled in a BadgerCare Plus HMO but has a baby outside the HMO network, the hospital provider or HMO is responsible for reporting the birth to ForwardHealth.

Hospitals, providers, or HMOs should complete and submit **one** newborn report per newborn, depending on the enrollment status of the mother. For example, if the mother is enrolled in an HMO, the HMO **or** the hospital should report the newborn. Providers should not submit reports as long as the HMO or the hospital is reporting the newborn.

Newborns should be reported to ForwardHealth even in instances in which the baby is born alive but does not survive or if the baby is not staying with the mother after birth.

Newborn Report Submission

Providers are encouraged to submit a newborn report soon after a baby is born to avoid a delay in establishing the baby's enrollment in BadgerCare Plus or the mother's BadgerCare Plus HMO. Before completing a newborn report, providers should verify that the baby has not already been enrolled. This verification could save time and avoid the possibility of the baby having multiple records.

Providers should not use the EE (Express Enrollment) process if the mother is enrolled in BadgerCare Plus or Wisconsin Medicaid at the time of birth.

For privacy and security purposes, providers should **not** submit newborn reports via email.

Newborn Reporting Wizard

Providers may report newborn births by using the newborn reporting wizard located on the ForwardHealth Portal. They should start by searching for the mother using one of the following criteria:

- Member ID
- Social Security number (no dashes) and date of birth (mm/dd/yyyy)
- Member first name, last name, and date of birth (mm/dd/yyyy)

Required newborn information includes the following:

- First name, or if not available, Boy or Girl
- Middle initial (if applicable)
- Last name
- Gender
- Date of birth (in mm/dd/yyyy)
- Date of death (in mm/dd/yyyy [if applicable])
- Social Security number (no dashes)
- Indication if the baby is entering foster care, adoption, or Safe Haven
- Indication if newborn's address is different than the mother's
- Phone number (if a phone type is selected)
- Full address if the address is different from the mother's and the newborn is not going to foster care, adoption, or Safe Haven
- Indication if newborn weight is less than 1200 grams
- Newborn weight (if applicable)
- Gestational age (weeks)

Providers may select the Multiple Births option to report up to nine multiple births in the online newborn reporting wizard.

All required fields must be completed. If not, the newborn report cannot be submitted online.

Newborn reports should be submitted only for babies born to mothers enrolled in BadgerCare Plus or Wisconsin Medicaid.

Refer to the Newborn Reporting User Guide on the User Guides page of the Portal for more detailed instructions.

Fax or Mail

Providers may report the birth of a baby by submitting the Newborn Report form by fax or by mail as long as all information required on the Newborn Report form is provided. Required information includes the following:

- Provider's name
- Contact name and telephone number
- Baby's last name
- Baby's gender
- Baby's date of birth (in mm/dd/yyyy format)
- Indication if newborn weight is less than 1200 grams
- Newborn weight*
- Gestational age*
- Mother's full name
- Mother's member ID number
- Mother's full address
- Provider representative signature
- Date the report was completed

*Required for babies born in Milwaukee, Waukesha, Washington, Ozaukee, Kenosha, and Racine counties.

Providers are required to report each baby on separately.

Newborn reports may be submitted by fax to 608-224-6318 or by mail to the following address:

ForwardHealth
PO Box 6470
Madison WI 53716

For privacy and security purposes, providers should **not** submit newborn reports via email.

If incomplete information is provided or if multiple babies are listed on one newborn report, the report will be returned to the contact person indicated on the report in the manner in which it was submitted.

Newborn reports should be submitted only for babies born to mothers enrolled in BadgerCare Plus or Wisconsin Medicaid.

Reporting a Newborn's Name

Although the baby's first name may not be available at the time the newborn report is ready to be submitted, **every** effort should be made to provide the first name, rather than a generic "Girl," "Boy," or "Baby." The first name is important in order to prevent assigning multiple ID numbers to the same baby and to ensure that the name is included on the ForwardHealth ID card. Since the baby's eligibility is backdated to the date of birth, delaying the submission of the report for a short time to include all information will not affect payment of services.

Providers are required to indicate a baby's last name on the report.

Newborn Report Procedures

Once the completed newborn report is submitted, the following procedures take place:

- A ForwardHealth ID number is assigned to the newborn if there is not an existing ID number on file.
- A ForwardHealth card is issued to the child as soon as the child's BadgerCare Plus enrollment is put on file.
- A letter is sent to the child's primary casehead, notifying them of the child's enrollment.

Babies Born to Mothers Not Enrolled in BadgerCare Plus or Wisconsin Medicaid

If a mother was not enrolled in BadgerCare Plus or Wisconsin Medicaid at the time of birth, providers should not report the newborn. The mother may apply for eligibility for the baby through an income maintenance or tribal agency. The newborn may also be enrolled through the EE process.

If the mother was not enrolled in BadgerCare Plus or Wisconsin Medicaid at the time of birth, she can apply for benefits retroactively. If her dates of enrollment include the date of the baby's birth, the baby may also be able to receive retroactive and continuous enrollment for the first year of life.

Providers with questions regarding newborn enrollment or newborn reporting may call Provider Services.

Topic #277

Non-U.S. Citizens — Emergency Services

Certain non-U.S. citizens who are not qualified aliens are eligible for services only in cases of acute emergency medical conditions. Providers should use the appropriate diagnosis code to document the nature of the emergency.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of such severity that one could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the person's health in serious jeopardy
- Serious impairment to bodily functions

- Serious dysfunction of any bodily organ or part

Due to federal regulations, BadgerCare Plus and Wisconsin Medicaid do not cover services for non-U.S. citizens who are not qualified aliens related to routine prenatal or postpartum care, major organ transplants (for example, heart, liver), or ongoing treatment for chronic conditions where there is no evidence of an acute emergent state. For the purposes of this policy, services for ESRD (end-stage renal disease) and all labor and delivery are considered emergency services.

Note: Babies born to certain non-qualifying immigrants are eligible for Medicaid enrollment under the CEN (continuously eligible newborn) option. However, babies born to women with incomes over 300% of the FPL (Federal Poverty Level) are not eligible for CEN status. The baby may still qualify for BadgerCare Plus. These mothers should report the birth to the local agencies within 10 calendar days.

A provider who gives emergency care to a non-U.S. citizen should refer them to the income maintenance or tribal agency or ForwardHealth outstation site for a determination of BadgerCare Plus enrollment. Providers may complete the Certification of Emergency for Non-U.S. Citizens (F-01162 (02/2009)) form for clients to take to the income maintenance or tribal agency in their county of residence where the BadgerCare Plus enrollment decision is made.

Providers should be aware that a client's enrollment does not guarantee that the services provided will be reimbursed by BadgerCare Plus.

Topic #278

Persons Detained by Legal Process

Most individuals detained by legal process who are eligible for BadgerCare Plus or Wisconsin Medicaid benefits will have their eligibility suspended during their detention period. During the suspension, ForwardHealth will only cover inpatient services received while the member is outside of jail or prison for 24 hours or more.

Note: Detained by legal process means a person who is incarcerated because of law violation or alleged law violation, which includes misdemeanors, felonies, delinquent acts, and day-release prisoners. Inmates who are released from jail under the Huber Program to return home to care for their minor children may be eligible for full benefit BadgerCare Plus or Wisconsin Medicaid without suspension.

Pregnant women detained by legal process who qualify for the BadgerCare Plus Prenatal Program and state prison inmates who qualify for Wisconsin Medicaid or BadgerCare Plus during inpatient hospital stays may receive certain benefits and are not subject to eligibility suspension. Additionally, inmates of county jails admitted to a hospital for inpatient services who are expected to remain in the hospital for 24 hours or more will be eligible for PE (presumptive eligibility) determinations for BadgerCare Plus by qualified hospitals. Refer to the Presumptive Eligibility chapter of either the Inpatient or Outpatient Hospital service area for more information on the PE determination process.

The DOC (Department of Corrections) or county jail oversee health care-related needs for individuals detained by legal process who do not qualify for the BadgerCare Plus Prenatal Program or for state prison inmates who do not qualify for Wisconsin Medicaid or BadgerCare Plus during an inpatient hospital stay.

Topic #16657

State Prison Inmates May Qualify for BadgerCare Plus or Wisconsin Medicaid During Inpatient Hospital Stays

As a result of 2013 Wisconsin Act 20, state prison inmates may qualify for BadgerCare Plus or Wisconsin Medicaid during inpatient hospital stays.

Eligibility

Most individuals detained by legal process who are eligible for BadgerCare Plus or Wisconsin Medicaid benefits will have their eligibility suspended during their detention period. During the suspension, ForwardHealth will only cover inpatient services received while the member is outside of jail or prison for 24 hours or more.

To qualify for BadgerCare Plus or Wisconsin Medicaid, prison or jail inmates must meet all applicable eligibility criteria. The DOC coordinates and reimburses inpatient hospital services for state prison inmates who do not qualify for BadgerCare Plus or Wisconsin Medicaid.

Inmates whose BadgerCare Plus or Wisconsin Medicaid eligibility has been suspended will have coverage of inpatient services for the duration of a hospital stay of 24 hours or more. This coverage begins on their date of admission and ends on their date of discharge.

Inmates are not eligible for outpatient hospital services, including observations, under BadgerCare Plus and Wisconsin Medicaid. Inmates may only be eligible for ER (emergency room) services if they are admitted to the hospital directly from the ER and are counted in the midnight census; otherwise, ER services are considered outpatient services. Outpatient hospital services approved by the DOC are reimbursed by the DOC.

Inmates are not presumptively eligible. Retroactive eligibility will only apply to dates of admission on and after April 1, 2014.

Enrollment

The DOC coordinates the submission of enrollment applications on behalf of state prison inmates.

Covered Services

The only services allowable by BadgerCare Plus or Wisconsin Medicaid for inmates are inpatient hospital services and professional services provided during the inpatient hospital stay that are covered under BadgerCare Plus and Wisconsin Medicaid. Providers with questions regarding services covered by BadgerCare Plus and Wisconsin Medicaid may refer to the applicable service area or contact Provider Services.

Fee-for-Service

Inmates receive services on a fee-for-service basis; they are not enrolled in HMOs.

HMO

BadgerCare Plus and Medicaid SSI members who are incarcerated for 30 or more calendar days will be automatically enrolled in fee-for-service Medicaid. These members will be removed from their previous enrollment in BadgerCare Plus and Medicaid SSI HMOs. Members are identified as incarcerated if their circumstance meets the federal definition of inmate of a public institution, per 42 C.F.R. § 435.1010.

When ForwardHealth is made aware of a member's incarceration status being longer than 30 days, it will retroactively disenroll that member from any HMO. Medicaid fee-for-service coverage will begin the first day of the month when the member's incarceration began. For example, if a member was incarcerated on October 10, HMO enrollment will be end-dated effective September 30, and fee-for-service enrollment will be effective October 1.

ForwardHealth can disenroll a member from their HMO retroactive to as many as 12 months.

Members incarcerated for less than 30 days will remain enrolled in their HMOs. However, providers must bill any inpatient hospital stays and professional services associated with hospital stays for these members to fee-for-service Medicaid. These

claims must be submitted as extraordinary claims.

Prior Authorization

The DOC will assist inpatient hospital providers with their submission of PA (prior authorization) requests for any services requiring PA. If PA is denied, the DOC is responsible for reimbursement of the services.

Enrollment Verification

Inmates are only enrolled for the duration of their hospital stay. Providers should always verify an inmate's enrollment in BadgerCare Plus or Wisconsin Medicaid before submitting a claim.

Claim Submission

When submitting a claim for an inmate's inpatient hospital stay, providers should follow the current claim submission procedures for each applicable service area.

Reimbursement

Acute care hospitals that provide services to inmates are reimbursed at a percentage of their usual and customary charge.

Critical access hospitals that provide services to inmates are reimbursed according to their existing Wisconsin Medicaid reimbursement methodology.

Wisconsin Medicaid reimburses professional services related to an inmate's inpatient hospital stay (for example, laboratory services, physician services, radiology services, or DME (durable medical equipment)) at the current maximum allowable fee.

Contact Information

Providers may contact the DOC at 608-240-5150 with questions regarding enrollment or PA for inmate inpatient hospital stays.

Topic #280

Retroactive Enrollment

Retroactive enrollment occurs when an individual has applied for BadgerCare Plus or Medicaid and enrollment is granted with an effective date prior to the date the enrollment determination was made. A member's enrollment may be backdated to allow retroactive coverage for medical bills incurred prior to the date of application.

The retroactive enrollment period may be backdated up to three months prior to the month of application if all enrollment requirements were met during the period. Enrollment may be backdated more than three months if there were delays in determining enrollment or if court orders, fair hearings, or appeals were involved.

Reimbursing Members in Cases of Retroactive Enrollment

When a member receives retroactive enrollment, he or she has the right to request the return of payments made to a Medicaid-enrolled provider for a covered service during the period of retroactive enrollment, according to Wis. Admin. Code § DHS 104.01(11). A Medicaid-enrolled provider is required to submit claims to ForwardHealth for covered services provided to a member during periods of retroactive enrollment. Medicaid cannot directly refund the member.

If a service(s) that requires PA (prior authorization) was performed during the member's period of retroactive enrollment, the

provider is required to submit a PA request and receive approval from ForwardHealth **before** submitting a claim.

If a provider receives reimbursement from Medicaid for services provided to a retroactively enrolled member and the member has paid for the service, the provider is required to reimburse the member or authorized person acting on behalf of the member (for example, local General Relief agency) the full amount that the member paid for the service.

If a claim cannot be filed within 365 days of the DOS (date of service) due to a delay in the determination of a member's retroactive enrollment, the provider is required to submit the claim to Timely Filing within 180 days of the date the retroactive enrollment is entered into Wisconsin's EVS (Enrollment Verification System) (if the services provided during the period of retroactive enrollment were covered).

Topic #546

Physician Services and Retroactive Coverage

Physician services providers should do the following when a member is granted retroactive enrollment and the service performed:

- **Required PA.** 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 (Prior Authorization Request Form, F-11018 (04/2026)).
- **Was a sterilization procedure**. If the provider performed a sterilization procedure during a period of retroactive eligibility before the member was enrolled in Medicaid or BadgerCare Plus, and the provider has met all federal regulations including completing a required Consent for Sterilization (DMS-1000 (05/2025)) form at least 30 days prior to the procedure, then a claim for the sterilization may be submitted to ForwardHealth for reimbursement.

  If one or more of the federal requirements has not been met, including completing the consent form at least 30 days prior to the procedure, the sterilization service is considered not covered and the provider may not receive Medicaid reimbursement; however, the provider may bill the member. This policy applies to the sterilization procedure and any services related to the procedure.

  To help facilitate reimbursement for sterilizations, it is recommended that providers use the Consent for Sterilization form before **all** sterilizations in the event that the applicant obtains Medicaid retroactive eligibility.

- **Was a hysterectomy procedure**. If the member underwent a hysterectomy, the hysterectomy may be reimbursed if the provider attests in a signed statement uploaded via the Portal for electronically submitted claims or attached to a 1500 Health Insurance Claim Form ((02/12)) that the member was, at a minimum:
  - Informed that the surgery would make the member permanently incapable of reproducing
  - Already sterile
  - In a life-threatening situation that required a hysterectomy

Topic #281

Spenddown to Meet Financial Enrollment Requirements

Occasionally, an individual with significant medical bills meets all enrollment requirements except those pertaining to income. These individuals are required to "spenddown" their income to meet financial enrollment requirements.

The certifying agency calculates the individual's spenddown (or deductible) amount, tracks all medical costs the individual incurs, and determines when the medical costs have satisfied the spenddown amount. (A payment for a medical service does not have to be made by the individual to be counted toward satisfying the spenddown amount.)

When the individual meets the spenddown amount, the certifying agency notifies ForwardHealth and the provider of the last service that the individual is eligible beginning on the date that the spenddown amount was satisfied.

If the individual's last medical bill is greater than the amount needed to satisfy the spenddown amount, the certifying agency notifies the affected provider by indicating the following:

- The individual is eligible for benefits as of the DOS (date of service) on the last bill.
- A claim for the service(s) on the last bill should be submitted to ForwardHealth. (The claim should indicate the full cost of the service.)
- The portion of the last bill that the individual must pay to the provider.

The certifying agency also informs ForwardHealth of the individual's enrollment and identifies the following:

- The DOS of the final charges counted toward satisfying the spenddown amount
- The provider number of the provider of the last service
- The spenddown amount remaining to be satisfied

When the provider submits the claim, the spenddown amount will automatically be deducted from the provider's reimbursement for the claim. The spenddown amount is indicated in the Member's Share element on the Medicaid Remaining Deductible Update (F-10109 (02/2014)) form sent to providers by the member's certifying agency. The provider's reimbursement is then reduced by the amount of the member's obligation.

Prior Authorization

6

Archive Date:10/01/2026

Prior Authorization:Advanced Imaging Services

Topic #10678

Prior Authorization for Advanced Imaging Services

Most advanced imaging services, including CT (computed tomography), MR (magnetic resonance), MRE (magnetic resonance elastography), and PET (positron emission tomography) imaging, require PA (prior authorization) when performed in either outpatient hospital settings or in non-hospital settings (for example, radiology clinics). eviCore healthcare, a private radiology benefits manager, is authorized to administer PA for advanced imaging services on behalf of ForwardHealth. Additional information about PA requirements and submission information for advanced imaging services is available.

Decisions

Topic #424

Approved Requests

PA (Prior authorization) requests are approved for varying periods of time based on the clinical justification submitted. The provider receives a copy of a PA decision notice when a PA request for a service is approved. Providers may then begin providing the approved service on the grant date given.

An approved request means that the requested **service**, not necessarily the code, was approved. For example, a similar procedure code may be substituted for the originally requested procedure code. Providers are encouraged to review approved PA requests to confirm the services authorized and confirm the assigned grant and expiration dates.

Listing Procedure Codes Approved as a Group on the Decision Notice Letter

In certain circumstances, ForwardHealth will approve a PA request for a group of procedure codes with a total quantity approved for the entire group. When this occurs, the quantity approved for the entire group of codes will be indicated with the first procedure code. All of the other approved procedure codes within the group will indicate a quantity of zero.

Providers may submit claims for any combination of the procedure codes in the group up to the approved quantity.

Topic #4724

Communicating Prior Authorization Decisions

ForwardHealth will make a decision regarding a provider's PA (prior authorization) request within 20 working days from the receipt of all the necessary information. After processing the PA request, ForwardHealth will send the provider a decision notice letter. Providers will receive a decision notice letter for PA requests that were approved, approved with modifications, or denied. The decision notice 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 via the Portal.

Topic #5037

Decision Notice Letters and Returned Provider Review Letters on the Portal

Providers can view PA (prior authorization) decision notices and provider review letters via the secure area of the ForwardHealth Portal. PA decision notices and provider review letters can be viewed when the PA is selected on the Portal.

Note: The PA decision notice or the provider review letter will not be available until the day after the PA request is processed by ForwardHealth.

Topic #425

Denied Requests

When a PA (prior authorization) request is denied, both the provider and the member are notified. The provider receives a PA decision notice, including the reason for PA denial. The member receives a Notice of Appeal Rights letter that includes a brief statement of the reason PA was denied and information about their 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:

- Choose not to provide the service.
- Submit a **new** PA request. Providers are required to submit a copy of the original denied PA request and additional supporting clinical documentation and medical justification along with a new PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) or PA/DRF (Prior Authorization/Dental Request Form, F-11035 (06/2024)).
- Provide the service as a noncovered service.

The member may choose to receive a service as a noncovered service:

- When the member does not appeal the decision of the denied PA request.
- When the member appeals the decision but the decision is upheld.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

   Division of Hearings and Appeals
   Department of Administration
   PO Box 7875
   Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #426

Modified Requests

Modification is a change in the services originally requested on a PA (prior authorization) request. Modifications could include, but are not limited to, either of the following:

- The authorization of a procedure code different than the one originally requested.
- A change in the frequency or intensity of the service requested.

When a PA request is modified, both the provider and the member are notified. The provider will be sent a decision notice letter. The decision notice letter will clearly indicate what is approved or what correction or additional information is needed to continue adjudicating the PA request. The member receives a Notice of Appeal Rights letter that includes a brief statement of the reason PA was modified and information on their right to a fair hearing. Only the **member, or authorized person acting on behalf of the member**, can appeal the modification.

Providers are required to discuss with the member the reasons a PA request was modified.

Providers have the following options when a PA request is approved with modification:

- Provide the service as authorized.
- Submit a request to amend the modified PA request. Additional supporting clinical documentation and medical justification must be included.
- Not provide the service.
- Provide the service as originally requested as a noncovered service.

If the member does not appeal the decision to modify the PA request or appeals the decision but the decision is upheld and the member chooses to receive the originally requested service anyway, the member may choose to receive the service(s) as a noncovered service.

Providers may call Provider Services for clarification of why a PA request was modified.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

XXXXXXXXXXXXXXXXXXXXXXXXX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

    Division of Hearings and Appeals
    Department of Administration
    PO Box 7875
    Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.

- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #4737

Returned Provider Review Letter Response Time

Thirty Days to Respond to the Returned Provider Review Letter

ForwardHealth must receive the provider's response within 30 calendar days of the date on the returned provider review letter, whether the letter was sent to the provider by mail or through the ForwardHealth Portal. If the provider's response is received within 30 calendar days, ForwardHealth still considers the original receipt date on the PA (prior authorization) request when authorizing a grant date for the PA.

If a provider needs more than 30 days to submit the requested information, providers can request an extension by submitting a letter that explains why more time is needed to gather and submit the additional information requested. The letter seeking an extension must be submitted within the initial 30 calendar days of receiving the returned provider review letter.

Instructions for how to submit the letter can be found in the ForwardHealth Provider Portal Prior Authorization User Guide. If a provider wants to submit the letter via mail or fax, the provider must ensure it is received within the 30 days. While mailed or faxed letters are accepted, providers are encouraged to submit the letter via electronic upload.

Providers will be notified in a manner similar to how they submitted their letter, and the new deadline will be included in that notification. Providers who mail their submissions will receive a notification in the mail. Providers who electronically upload their submission will receive a notification in the Portal, etc.

If ForwardHealth does not receive the provider's response within 30 calendar days of the date the returned provider review letter was sent, the PA status becomes inactive and the provider is required to submit a new PA request. This results in a later grant date if the PA request is approved. Providers will not be notified when their PA request status changes to inactive, but this information will be available on the Portal and through WiCall.

If ForwardHealth receives additional information from the provider after the 30-day deadline has passed, a letter will be sent to the provider stating that the PA request is inactive and the provider is required to submit a new PA request.

Topic #427

Returned Requests

A PA (prior authorization) request may be returned to the provider when forms are incomplete, inaccurate, or additional clinical information or corrections are needed. When this occurs, the provider will be sent a provider review letter.

Returned Provider Review Letter

The returned provider review letter will indicate the PA number assigned to the request and will specify corrections or additional information needed on the PA request. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct PAs that have been placed in returned provider review status in the ForwardHealth Portal.

If providers require more than 30 days submit corrections or required additional information, they can request an extension by submitting a letter that explains why more time is needed. The letter requesting an extension must be submitted within the initial 30 calendar days of receiving the returned provider review letter.

Instructions for how to submit the letter can be found in the ForwardHealth Provider Portal Prior Authorization User Guide. If a provider wants to submit the letter via mail or fax, the provider must ensure it is received within the 30 days. While mailed or faxed letters are accepted, providers are encouraged to submit the letter via electronic upload.

Providers will be notified in a manner similar to how they submitted their letter, and the new deadline will be included in that notification. Providers who mail their submissions will receive a notification in the mail. Providers who electronically upload their submission will receive a notification in the Portal, etc.

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, dental models will be returned once the PA is finalized.

Photographs and digital scans submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

Therefore, providers are required to make a copy of their PA requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if more information is required about the PA request.

Note: When changing or correcting the PA request, providers are reminded to revise or update the documentation retained in their records.

Emergent and Urgent Situations

Topic #429

Emergency Services

In emergency situations, the PA (prior authorization) requirement may be waived for services that normally require PA. Emergency services are defined in Wis. Admin. Code DHS 101.03(52) as "those services which are necessary to prevent the death or serious impairment of the health of the individual."

Reimbursement is not guaranteed for services that normally require PA that are provided in emergency situations. As with all covered services, emergency services must meet all program requirements, including medical necessity, to be reimbursed by Wisconsin Medicaid. For example, reimbursement is contingent on, but not limited to, eligibility of the member, the circumstances of the emergency, and the medical necessity of the services provided.

Wisconsin Medicaid will not reimburse providers for noncovered services provided in any situation, including emergency situations.

Topic #430

Urgent Situations

If a PA (prior authorization) request is required for an urgent situation, providers are required to submit the PA request in the ForwardHealth Portal.

ForwardHealth defines a PA request for a medically urgent situation as any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could have the following impact:

- Seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment.
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Follow-Up to Decisions

Topic #4738

Amendment Decisions

ForwardHealth will make a decision regarding a provider's amendment request within 20 working days from the receipt of all the necessary information. The method ForwardHealth will use to communicate decisions regarding PA (prior authorization) amendment requests will depend on how the **PA request** was originally submitted (not how the amendment request was submitted) and whether the provider has a ForwardHealth Portal account. If the PA request was originally submitted via the Portal, the decision notice letter will be sent to the provider via the Portal.

Topic #431

Amendments

Providers are required to use the Prior Authorization Amendment Request (F-11042 (07/2012)) form to amend an approved or modified PA (prior authorization) request.

ForwardHealth does not accept a paper amendment request submitted on anything other than the Prior Authorization Amendment Request form. The Prior Authorization Amendment Request form may be submitted through the Portal, by mail or by 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 form.

Providers may request an amendment to an approved or modified PA request to:

- Temporarily modify a member's frequency of a service when there is a short-term change in their medical condition.
- Change the rendering provider information when the billing provider remains the same.
- Change the member's ForwardHealth identification number.
- Add or change a procedure code.

Note: ForwardHealth recommends that, under most circumstances, providers should enddate the current PA request and submit a new one if there is a significant, long-term change in services required.

Topic #432

Appeals

If a PA (prior authorization) request is denied or modified by ForwardHealth, only a member, or authorized person acting on behalf of the member, may file an appeal with the DHA (Division of Hearings and Appeals). Decisions that may be appealed include the following:

- Denial or modification of a PA request
- Denial of a retroactive authorization for a service

The member is required to file an appeal within 45 days of the date of the Notice of Appeal Rights.

To file an appeal, members may complete and submit a Request for Fair Hearing (DHA-28 (08/09)) form.

Though providers cannot file an appeal, they are encouraged to remain in contact with the member during the appeal process. Providers may offer the member information necessary to file an appeal and help present their 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 to submit a claim for the service, the provider should submit the following to ForwardHealth after the service has been performed:

- A paper claim with "HEARING DECISION ATTACHED" written in red ink at the top of the claim
- A copy of the hearing decision
- A copy of the denied PA request

Providers are required to submit claims with hearing decisions to the following address:

ForwardHealth
Specialized Research
Ste 50
313 Blettner Blvd
Madison WI 53784

Claims with hearing decisions sent to any other address may not be processed appropriately.

If the DHA letter instructs the provider to submit a new PA request, the provider is required to submit the **new** PA request along with a copy of the hearing decision to the PA Unit at the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

ForwardHealth will then approve the PA request with the revised process date. The provider may then submit a claim following the usual claims submission procedures after providing the service(s).

Financial Responsibility

If the member asks to receive the service **before** the hearing decision is made, the provider is required to notify the member before rendering the service that the member will be responsible for payment if the decision to deny or modify the PA request is upheld.

If the member accepts responsibility for payment of the service before the hearing decision is made, and if the appeal decision

upholds the decision to deny or modify the PA request, the provider may collect payment from the member if certain conditions are met.

If the member accepts responsibility for payment of the service before the hearing decision is made, and if the appeal decision **overturns** the decision to deny or modify a PA request, the provider may submit a claim to ForwardHealth. If the provider collects payment from the member for the service before the appeal decision is overturned, the provider is required to refund the member for the **entire** amount of payment received from the member after the provider receives Medicaid's reimbursement.

Wisconsin Medicaid does not directly reimburse members.

Topic #1106

Enddating

Providers are required to use the Prior Authorization Amendment Request (F-11042 (07/2012)) to end date most PA (prior authorization) requests. ForwardHealth does not accept requests to end date a PA request for any service, except drugs, on anything other than the Prior Authorization Amendment Request. PA for drugs may be end-dated by using STAT-PA (Specialized Transmission Approval Technology-Prior Authorization), in addition to submitting a Prior Authorization Amendment Request.

Providers may submit a Prior Authorization Amendment Request on the ForwardHealth Portal, or by fax or mail.

If a request to end date 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 end-dated 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 end-dated and a new PA request should be submitted include the following:

- There is an interruption in a member's continual care services.
- There is a change in the member's condition that warrants a long-term change in services required.
- The service(s) is no longer medically necessary.

Topic #5039

Searching for Previously Submitted Prior Authorization Requests on the Portal

Providers will be able to search for all previously submitted PA (prior authorization) requests, regardless of how the PA was initially submitted. If the provider knows the PA number, they can enter the number to retrieve the PA information. If the provider does not know the PA number, they can search for a PA by entering information in one or more of the following fields:

- Member identification number
- Requested start date
- Prior authorization status
- Amendment status

If the provider does not search by any of the information above, providers will retrieve all their PA requests submitted to ForwardHealth.

Forms and Attachments

Topic #960

An Overview

Depending on the service being requested, most PA (prior authorization) requests must be comprised of:

- The PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) and the PA/DRF (Prior Authorization/Dental Request Form, F-11035 (06/2024))
- A service-specific PA attachment(s)
- Additional supporting clinical documentation (Typical PA requirements regarding attachments may not apply for some HealthCheck Other Services PA requests.)

Topic #446

Attachments

In addition to the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) or PA/DRF (Prior Authorization/Dental Request Form, F-11035 (06/2024)), a service-specific PA (prior authorization) attachment must be submitted with each PA request. The PA attachment allows a provider to document the clinical information used to determine whether or not the standards of medical necessity are met for the requested service(s). Providers should include adequate information for ForwardHealth to make a reasonable judgment about the case.

To reduce processing time for mailed or faxed pharmacy PA requests, ForwardHealth will scan each form with a barcode as it is received.

Topic #527

Prior Authorization/Physician Attachment

The PA/PA (Prior Authorization/Physician Attachment, F-11016 (07/2012)) 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/Physician-Administered Drug Attachment

The purpose of the PA/PAD (Prior Authorization/Physician-Administered Drug Attachment, F-11034 (07/2022)) form is to document the medical necessity of physician-administered drugs requiring PA.

Prior Authorization/Physician Otological Report

Completion of the PA/POR (Prior Authorization/Physician Otological Report, F-11019 (07/2012)) begins the process by which PA is obtained for a hearing aid by a hearing instrument specialist. The physician gives page one (or a copy) of the completed PA/POR to the member and keeps page two (or a copy of it) in the member's medical records. The member then takes the PA/POR to any Medicaid-enrolled hearing instrument specialist to receive a hearing aid.

Topic #447

Obtaining Forms and Attachments

Only pharmacy providers may obtain paper versions of all PA (prior authorization) forms and attachments. All other providers must complete most PA attachments from the ForwardHealth Portal.

Paper Forms (for Pharmacy Providers Only)

Paper versions of all PA forms and PA attachments are available by writing to ForwardHealth. Include a return address, the name of the form, the form number (if applicable), and mail the request to the following address:

ForwardHealth
Form Reorder
313 Blettner Blvd
Madison WI 53784

Providers may also call Provider Services to order paper copies of forms.

Downloadable Forms (for Pharmacy Providers Only)

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 PA Via the Portal

Providers may complete the PA/RF (Prior Authorization Request Form, F-11018 (07/2026)) and PA attachments through the Portal.

Topic #448

Prior Authorization Request Form

The PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) is used by ForwardHealth and is mandatory for most providers when requesting PA (prior authorization). The PA/RF serves as the cover page of a PA request.

Note: When submitting PA requests on the Portal, providers will see panels that will prompt them to answer the questions on the PA/RF. The Portal will generate a PA/RF for them at the end of the process.

Providers are required to complete the basic provider, member, and service information on the PA/RF. Each PA request is assigned a unique ten-digit number. ForwardHealth remittance information will report to the provider the PA number used to process the claim for prior authorized services.

Under Wis. Stat. § 49.45(4), 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.

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

Providers should use the following process types on the PA/RF to request PA for the corresponding service areas.

Process Type	Description
111	Physical therapy
112	Occupational therapy
113	Speech and language therapy
117	Physician services, including rural health clinics and federally qualified health centers
	Physician-administered drugs
	Botox to treat migraines
	IV ketamine infusion therapy
118	Chiropractic
120	Home care
	Home health therapy
	Intermittent skilled nursing
	Private duty nursing
121	Personal care
122	Vision
123	Audiology/Hearing aid
124	Dental
125	Orthodontics
126	Intensive in-home treatment service, HealthCheck Other Service
127	Genetic testing
129	Child/adolescent day treatment, a HealthCheck Other Service
	Adult mental health day treatment
130	DME (durable medical equipment): Wheelchairs, accessories, and home health equipment
	DME: Pediatric hospital beds and cribs
131	Drugs
132	DMS (disposable medical supplies)
133	Transplants
135	Ventilators
136	Substance abuse day treatment
139	Oxygen and respiratory equipment
140	DME: Orthotics, footwear, prosthetics
142	Behavioral treatment
145	Residential substance use disorder
146	Housing support

148	Intensive outpatient program
160	Physical therapy Birth to 3
161	Occupational therapy Birth to 3
162	Speech and language therapy Birth to 3
999	Brain injury
	Ambulance

Topic #22580

Prior Authorization/Physician-Administered Drug Attachment

Individual sections on the PA/PAD (Prior Authorization/Physician-Administered Drug Attachment, F-11034 (07/2022)) form identify specific types of physician-administered drug PA (prior authorization) requests that require clinical PA, and ForwardHealth has defined criteria for those sections. Prescribers must submit the PA/PAD form along with the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) to request PA.

When completing the PA/PAD form, prescribers must complete the most appropriate section as it pertains to the physician-administered drug being requested. The specific sections are as follows:

- Clinical information for diagnosis-restricted physician-administered drug requests
- Clinical information for physician-administered drugs with specific PA criteria addressed in the ForwardHealth Online Handbook
- Clinical information for other physician-administered drug requests
- Additional information (Prescribers should complete this section if more space is needed on the PA/PAD form, or the prescriber is including additional information.)

Prescribers must fill out the appropriate section(s), then sign and date the PA/PAD form.

PA requests for physician-administered drugs must be completed, signed, and dated by the prescriber. PA requests for physician-administered drugs must be submitted using the PA/PAD form. Clinical documentation supporting the use of a physician-administered drug must be submitted with the PA request.

Prescribers are required to submit the completed PA/PAD form and a completed PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) to ForwardHealth.

PA requests for physician-administered drugs may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Prescribers are reminded that they are required to complete, sign, and date each PA form when submitting the PA request. Prescribers are required to retain a completed copy of the PA request form(s).

Clinical Information for Diagnosis-Restricted Physician-Administered Drug Requests

If the prescriber orders a drug that is a physician-administered drug with a diagnosis outside the ForwardHealth-allowed diagnoses, the prescriber must submit peer-reviewed medical literature to support the proven efficacy and safety of the requested

use of the physician-administered drug. Prescribers must also include documentation of previous treatments and detailed reasons why other covered drug treatments were discontinued or not used. Medical records should be provided as necessary to support the PA request.

This information should be documented in Section IV (Clinical Information for Diagnosis-Restricted Physician-Administered Drug Requests) of the PA/PAD form.

When completing the PA/PAD form, prescribers should provide the diagnosis code and description, complete Section IV, and use Section VII (Additional Information) if needed. Prescribers are reminded to sign and date the form before submitting the PA/PAD form and the PA/RF to ForwardHealth. Clinical documentation supporting the use of the physician-administered drug must be submitted with the PA request.

Clinical Information for Physician-Administered Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook

If the prescriber orders one of the following drugs, a PA request must be submitted on the PA/PAD form:

- Leqvio
- Omvoh IV
- OnabotulinumtoxinA (Botox) (Note: The PA/PAD form must be submitted for a PA request if the prescriber is ordering Botox for a member in a manner that is not consistent with the guidance provided in the Online Handbook.)
- Skyrizi IV
- Tremfya IV

This information should be documented using Section V (Clinical Information for Physician-Administered Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/PAD form. Prescribers should refer to the appropriate topic in the Online Handbook for the drug-specific clinical PA criteria.

When completing the PA/PAD form, prescribers should provide the diagnosis code and description, complete Section V, and use Section VII (Additional Information) if needed. Prescribers are reminded to sign and date the form before submitting the PA/PAD with the PA/RF to ForwardHealth. Clinical documentation supporting the use of the physician-administered drug must be submitted with the PA request.

Clinical Information for Other Physician-Administered Drug Requests

If the prescriber orders a drug that is a physician-administered drug that requires the use of the PA/PAD form and has not been previously referenced in the above PA/PAD sections, the prescriber must document the clinical rationale to support the medical necessity of the physician-administered drug being requested. Documentation of previous treatments and detailed reasons why other covered drug treatments were discontinued or not used is required. Medical records and peer-reviewed medical literature should be provided as necessary to support the PA request.

PA documentation must demonstrate that the member has a medical condition for which the requested drug has FDA (Food and Drug Administration) approval. (Medical records must be provided to verify the member's medical condition.)

Additionally, the drug must be prescribed in a dose and manner consistent with the FDA-approved product labeling.

This information should be documented in Section VI (Clinical Information for Other Physician-Administered Drug Requests) of the PA/PAD form.

When completing the PA/PAD form, prescribers should provide the diagnosis code and description, complete Section VI, and use Section VII (Additional Information) if needed. Prescribers are reminded to sign and date the form before submitting the PA/PAD form with the PA/RF to ForwardHealth. Clinical documentation supporting the use of the physician-administered drug

must be submitted with the PA request.

Additional Information

Additional diagnostic and clinical information explaining the need for the drug requested may be included in Section VII of the PA/PAD form. If the space provided in the other sections is not sufficient, additional information may be included here.

Topic #449

Supporting Clinical Documentation

Certain PA (prior authorization) requests may require additional supporting clinical documentation to justify the medical necessity for a service(s). Supporting documentation may include, but is not limited to, X-rays, photographs, digital or physical models, intraoral photographs, a provider'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. Dental models will be returned to providers.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

General Information

Topic #4402

An Overview

The PA (prior authorization) review process includes both a clerical review and a clinical review. The PA request will have one of the statuses detailed in this table.

Prior Authorization Status	Description
For All Providers	
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.
Inactive—Void	The PA request is either: - Submitted but not required. - A provider requests to rescind the PA request. - Submitted in error. - The request was sent to the incorrect payor. For example, the member is in an HMO that covers this service.
Incomplete—PA Denied	The PA request was denied because the request form was inaccurate or incomplete, and ForwardHealth requires a complete and accurate PA request to determine if an item or service is covered.
Pending—Dental Follow-up	The PA request is being reviewed by a Fiscal Agent dental specialist.
Pending—Fiscal Agent Review	The PA request is being reviewed by the Fiscal Agent.
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.
For Pharmacy Providers Only	
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.
Returned—Provider Review	The PA request was returned to the provider for correction or for additional information.

Topic #434

Communication With Members

ForwardHealth recommends that providers inform members that PA (prior authorization) is required for certain specified services **before** delivery of the services. Providers should also explain that, if required to obtain PA, they will be submitting member records and information to ForwardHealth on the member's behalf. Providers are required to keep members informed of the PA request status throughout the **entire** PA process.

Member Questions

A member may call Member Services to find out whether or not a PA request has been submitted and, if so, when it was received by ForwardHealth. The member will be advised to contact the provider if more information is needed about the status of an individual PA request.

Topic #435

Definition

PA (Prior authorization) is the electronic or written authorization issued by ForwardHealth to a provider prior to the provision of a service. In most cases, providers are required to obtain PA **before** providing services that require PA. When granted, a PA request is approved for a specific period of time and specifies the type and quantity of service allowed.

Topic #5098

Designating an Address for Prior Authorization Correspondence

Correspondence related to PA (prior authorization) will be sent to the practice location address on file with ForwardHealth unless the provider designates a separate address for receipt of PA correspondence. This policy applies to all PA correspondence, including decision notice letters and returned supplemental documentation such as dental models.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

Providers may designate a separate address for PA correspondence using the demographic maintenance tool.

Topic #4383

Prior Authorization Numbers

Upon receipt of the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)), ForwardHealth will assign a PA (prior authorization) number to each PA request.

The PA number consists of 10 digits, containing valuable information about the PA (for example, the date the PA request was received by ForwardHealth, the medium used to submit the PA request).

Each PA request is assigned a unique PA number. This number identifies valuable information about the PA. The following table

provides detailed information about interpreting the PA number.

Type of Number and Description	Applicable Numbers and Description
Media—One digit indicates media type.	Digits are identified as follows: 1 = paper; 2 = fax; 3 = STAT-PA (Specialized Transmission Approval Technology-Prior Authorization); 4 = STAT-PA; 5 = Portal; 6 = Portal; 7 = NCPDP (National Council for Prescription Drug Programs) transaction or 278 (278 Health Care Services Review—Request for Review and Response) transaction; 9 = eviCore healthcare
Year—Two digits indicate the year ForwardHealth received the PA request.	For example, the year 2008 would appear as 08.
Julian date—Three digits indicate the day of the year, by Julian date, that ForwardHealth received the PA request.	For example, February 3 would appear as 034.
Sequence number—Four digits indicate the sequence number.	The sequence number is used internally by ForwardHealth.

Topic #436

Reasons for Prior Authorization

Only about 4% of all services covered by Wisconsin Medicaid require PA (prior authorization). PA requirements vary for different types of services. Refer to ForwardHealth publications and Wis. Admin. Code ch. DHS 107 for information regarding services that require PA. According to Wis. Admin. Code § DHS 107.02(3)(b), PA is designed to:

- 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 Wisconsin DHS (Department of Health Services).

Providers should not request PA for services that do not require PA simply to determine coverage or establish a reimbursement rate for a manually priced procedure code. Also, new technologies or procedures do not necessarily require PA. Providers having difficulties determining whether or not a service requires PA may call Provider Services.

Topic #437

Referrals to Out-of-State Providers

PA (prior authorization) may be granted to out-of-state providers when nonemergency services are necessary to help a member attain or regain their health and ability to function independently. The PA request may be approved only when the services are not reasonably accessible to the member in Wisconsin.

Out-of-state providers are required to meet ForwardHealth's guidelines for PA approval. This includes sending PA requests,

required attachments, and supporting documentation to ForwardHealth before the services are provided.

Note: Emergency services provided out-of-state do not require PA; however, claims for such services must include appropriate documentation (for example, anesthesia report, medical record) to be considered for reimbursement. Providers are required to submit claims with supporting documentation on paper.

When a Wisconsin Medicaid provider refers a member to an out-of-state provider, the referring provider should instruct the out-of-state provider to go to the Provider Enrollment Information home page on the ForwardHealth Portal to complete a Medicaid Out-of-State Provider Enrollment Application.

All out-of-state nursing homes, regardless of location, are required to obtain PA for all services. All other out-of-state nonborder-status providers are required to obtain PA for all nonemergency services except for home dialysis supplies and equipment.

Topic #438

Reimbursement Not Guaranteed

Wisconsin Medicaid may decline to reimburse a provider for a service that has been prior authorized if one or more of these program requirements are not met:

- The service authorized on the approved PA (prior authorization) request is the service provided.
- The service is provided within the grant and expiration dates on the approved PA request.
- The member is eligible for the service on the date the service is provided.
- The provider is enrolled in Wisconsin Medicaid on the date the service is provided.
- The service is billed according to service-specific claim instructions.
- The provider meets other program requirements.

Providers may not collect payment from a member for a service requiring PA under any of these circumstances:

- The provider failed to seek PA before the service was provided.
- The service was provided before the PA grant date or after the PA expiration date.
- The provider obtained PA but failed to meet other program requirements.
- The service was provided before a decision was made, the member did not accept responsibility for the payment of the service before the service was provided, and the PA was denied.

There are certain situations when a provider may collect payment for services in which PA was denied.

Other Health Insurance Sources

Providers are encouraged, but not required, to request PA from ForwardHealth for covered services that require PA when members have other health insurance coverage. This is to allow payment by Wisconsin Medicaid for the services provided in the event that the other health insurance source denies or recoups payment for the service. If a service is provided before PA is obtained, ForwardHealth will not consider backdating a PA request solely to enable the provider to be reimbursed.

Topic #1268

Sources of Information

Providers should verify that they have the most current sources of information regarding PA (prior authorization). It is critical that providers and staff have access to these documents:

- Wisconsin Administrative Code: Chapters DHS 101–109 are the rules regarding Medicaid administration.
- Wisconsin Statutes: Sections 49.43–49.99 provide the legal framework for Wisconsin Medicaid.
- ForwardHealth Portal: The Portal gives the latest policy information for all providers, including information about Medicaid managed care enrollees.

Topic #812

Status Inquiries

Providers may inquire about the status of a PA (prior authorization) request through one of the following methods:

- Accessing WiCall, ForwardHealth's AVR (Automated Voice Response) system
- Calling Provider Services

Providers should have the 10-digit PA number available when making inquiries.

Topic #13697

Third-Party Websites

The ForwardHealth Portal allows providers access to all policy and billing information for BadgerCare Plus, Medicaid, SeniorCare, HDAP (Wisconsin HIV Drug Assistance Program), and WCDP (Wisconsin Chronic Disease Program) in one centralized place. PA (Prior authorization) request forms and information about ForwardHealth's policies should be obtained from the Portal or Provider Services. Third-party websites are not affiliated with or endorsed by ForwardHealth.

Grant and Expiration Dates

Topic #439

Backdating for Initial and Renewal Requests

Initial Requests

An initial PA (prior authorization) request is the original approved PA that starts specific medically necessary services for a member.

ForwardHealth may allow a PA request to be backdated if it is received within 14 calendar days of the requested start date. ForwardHealth will modify or deny a PA request if it is received more than 14 calendar days after the requested start date and does not meet the extraordinary circumstances criteria.

Renewal Requests

A renewal request is a new PA request to continue medically necessary services beyond the initial PA request's end date.

Backdating is not allowed when submitting an amendment request for continuous treatment. All PA amendment requests to extend treatment must be received by ForwardHealth **prior to the expiration date** of the current PA request.

Backdating may be allowed for all benefits that utilize a PA request (PA/RF (Prior Authorization Request Form, F-11018 (04/2026))) to continue treatment if it is received within 14 calendar days of the requested start date. ForwardHealth will modify or deny a PA request if it is received more than 14 calendar days after the requested start date and does not meet the extraordinary circumstances criteria.

Extraordinary Circumstances Criteria

ForwardHealth may approve a request for backdating if all of these conditions are met:

- The provider specifically requests backdating in writing on the PA request.
- The request includes clinical justification for beginning the service before PA was granted.
- The request includes the reason why the request was submitted more than 14 days after the requested start date.

Examples of extraordinary circumstances include:

- A court order or hearing decision requiring Wisconsin Medicaid coverage is attached to the PA request.
- The member is retroactively enrolled. (Indicate in Element 21 of the PA/RF that the service was provided during a period of member retroactive enrollment. In Element 15, indicate the actual date the service was provided.)
- The provider is on a correction plan.

If the PA request is modified or denied and a service has already been rendered, the provider cannot require payment from the member.

Topic #440

Expiration Date

The expiration (end) date of an approved or modified PA (prior authorization) request is the date through which services are prior authorized. PA requests are granted for varying periods of time. Expiration dates may vary and do not automatically expire at the end of the month or calendar year. In addition, providers may request a specific expiration date. Providers should carefully review all approved and modified PA requests and make note of the expiration dates.

Topic #441

Grant Date

The grant (start) date of an approved or modified PA (prior authorization) request is the first date in which services are prior authorized and will be reimbursed under this PA number. On a PA request, providers may request a specific date that they intend services to begin. If no grant date is requested or the grant date is illegible, the grant date will typically be the date the PA request was reviewed by ForwardHealth.

Member Eligibility Changes

Topic #443

Loss of Enrollment During Treatment

Some covered services consist of sequential treatment steps, meaning more than one office visit or service is required to complete treatment.

In most cases, if a member loses enrollment midway through treatment, or at any time between the grant and end dates, Wisconsin Medicaid will **not** reimburse services (including prior authorized services) provided during an enrollment lapse. Providers should not assume Wisconsin Medicaid covers completion of services after the member's enrollment has been terminated.

To avoid potential reimbursement problems when a member loses enrollment during treatment, providers should follow these procedures:

- Ask to see the member's ForwardHealth identification card to verify the member's enrollment or consult Wisconsin's EVS (Enrollment Verification System) before the services are provided at each visit.
- When the PA (prior authorization) request is approved, verify that the member is still enrolled and eligible to receive the service before providing it. An approved PA request does not guarantee payment and is subject to the enrollment of the member.

Members are financially responsible for any services received after their enrollment has ended. If the member wishes to continue treatment, it is a decision between the provider and the member whether the service should be given and how payment will be made for the service.

To avoid misunderstandings, providers should remind members that they are financially responsible for any continued care after their enrollment ends.

Topic #444

Retroactive Disenrollment From State-Contracted MCOs

Occasionally, a service requiring fee-for-service PA (prior authorization) is performed during a member's enrollment period in a state-contracted MCO (managed care organization). After the service is provided, and it is determined that the member should be retroactively disenrolled from the MCO, the member's enrollment is changed to fee-for-service for the DOS (date of service). The member is continuously eligible for BadgerCare Plus or Wisconsin Medicaid but has moved from MCO enrollment to fee-for-service status.

In this situation, the state-contracted MCO would deny the claim because the member was not enrolled on the DOS. Fee-for-service would also deny the claim because PA was not obtained.

Providers may take the following steps to obtain reimbursement in this situation:

- For a service requiring PA for fee-for-service members, the provider is required to submit a retroactive PA request. For a PA request submitted on paper, indicate "RETROACTIVE FEE-FOR-SERVICE" along with a written description of the

service requested/provided under "Description of Service." Also indicate the actual date(s) the service(s) was provided. For a PA request submitted via the ForwardHealth Portal, indicate "RETROACTIVE FEE-FOR-SERVICE" along with a description of the service requested/provided under the "Service Code Description" field or include additional supporting documentation. Also indicate the actual date(s) the service(s) was provided.

- If the PA request is approved, the provider is required to follow fee-for-service policies and procedures for claims submission.
- If the PA request is denied, Wisconsin Medicaid will not reimburse the provider for the services. A PA request would be denied for reasons such as lack of medical necessity. A PA request would not be denied due to the retroactive fee-for-service status of the member.

Topic #445

Retroactive Enrollment

If a service(s) that requires PA (prior authorization) was performed during a member's retroactive enrollment period, the provider is required to submit a PA request and receive approval from ForwardHealth **before** submitting a claim. For a PA request submitted on paper, indicate the words "RETROACTIVE ENROLLMENT" at the top of the PA request along with a written description explaining that the service was provided at a time when the member was retroactively enrolled under "Description of Service." Also include the actual date(s) the service(s) was provided. For a PA request submitted via the ForwardHealth Portal, indicate the words "RETROACTIVE ENROLLMENT" along with a description explaining that the service was provided at a time when the member was retroactively eligible under the "Service Code Description" field or include additional supporting documentation. Also include the actual date(s) the service(s) was provided.

If the member was retroactively enrolled, and the PA request is approved, the service(s) may be reimbursable, and the earliest effective date of the PA request will be the date the member receives retroactive enrollment. If the PA request is denied, the provider will not be reimbursed for the service(s). Members have the right to appeal the decision to deny a PA request.

If a member requests a service that requires PA before his or her retroactive enrollment is determined, the provider should explain to the member that he or she may be liable for the full cost of the service if retroactive enrollment is not granted and the PA request is not approved. This should be documented in the member's record.

Preferred Drug List

Topic #7817

Lipotropics, Omega-3 Acids

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

PA (prior authorization) is required for non-preferred lipotropics, omega-3 acids.

PA requests for non-preferred lipotropics, omega-3 acids must be completed, signed, and dated by the prescriber. PA requests for non-preferred lipotropics, omega-3 acids must be submitted using the Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids (F-00162 (07/2024)) form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. The prescriber should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids form and a completed PA/RF (F-11018 (04/2026)) to ForwardHealth.

PA requests for non-preferred lipotropics, omega-3 acids may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Information is available about general ForwardHealth policy for drugs that require PA approval, including what may **not** be considered criteria to support the need for a drug.

Conditions for Which PA Requests for Use of Non-Preferred Lipotropics, Omega-3 Acids Will Be Considered for Review

ForwardHealth will only consider PA requests for non-preferred lipotropics, omega-3 acids to treat the following identified clinical conditions:

- Severe hypertriglyceridemia
- ASCVD (atherosclerotic cardiovascular disease) risk reduction

Clinical Criteria for Non-Preferred Lipotropics, Omega-3 Acids for Severe Hypertriglyceridemia

Clinical criteria for approval of a PA request for non-preferred lipotropics, omega-3 acids for severe hypertriglyceridemia are **all** of the following:

- The member has a current or prior triglyceride level of 500mg/dL or greater.
- The member has taken the maximum dose of a preferred lipotropic, omega-3 acid for **at least three consecutive months** and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction.

A current lipid panel report completed within the past 30 days must be submitted with all PA requests.

If the clinical criteria for non-preferred lipotropics, omega-3 acids for severe hypertriglyceridemia are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests may be approved for up to 365 days if the member has been adherent with the prescribed treatment regimen and had a reduction in their triglyceride level compared to their baseline prior to the initiation of a non-preferred lipotropics, omega-3 acid.

Clinical Criteria for Non-Preferred Lipotropics, Omega-3 Acids for Atherosclerotic Cardiovascular Disease Risk Reduction

Clinical criteria for approval of a PA request for non-preferred lipotropics, omega-3 acids for ASCVD risk reduction are **all** of the following:

- The member must have taken a maximized statin regimen **for at least three consecutive months** with failure to reach a triglyceride level of less than 150 mg/dL. The member must continue to take the maximized statin regimen along with the non-preferred lipotropic, omega-3 acid.
- One of the following is true:
  - The member has clinical ASCVD, as evidenced by **one** of the following:
    - The member has CAD (coronary artery disease), which is supported by a history of myocardial infarction (heart attack), coronary revascularization, or angina pectoris.
    - The member has a history of stroke.
    - The member has symptomatic peripheral arterial disease as evidenced by **one** of the following:
      - Intermittent claudication with an ABI (ankle-brachial index) of less than or equal to 0.9
      - Peripheral arterial revascularization procedure or amputation due to atherosclerotic disease.
  - The member has diabetes mellitus and two or more of the following ASCVD risk factors:
    - Congestive heart failure
    - Current smoker
    - eGFR (estimated glomerular filtration rate) less than 60 mL/min/1.73 m^2
    - Hypertension
    - Obesity

A current lipid panel report completed within the past 30 days must be submitted with all PA requests.

If the clinical criteria for non-preferred lipotropics, omega-3 acids for ASCVD risk reduction are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for non-preferred lipotropics, omega-3 acids for ASCVD risk reduction may be approved for up to 365 days. Members must also continue to take the maximized statin treatment regimen during treatment with the non-preferred lipotropics, omega-3 acid.

Prior Authorization Guidelines

Topic #15557

Dorsal Column or Spinal Stimulator Surgeries

PA (prior authorization) is required for both a dorsal column (spinal cord) stimulator trial period and dorsal column implantation surgery. A separate PA is required for each.

All of the following criteria must be met for PA requests to be approved for temporarily implanted dorsal column stimulator electrodes for trial purposes:

- The member suffers from chronic, intractable pain.
- Other treatment modalities (pharmacological, surgical, physical, or psychological therapies) have been given an adequate trial and did not prove satisfactory or were judged to be unsuitable or contraindicated for the member. The implantation of the dorsal column stimulator is a treatment of late or last resort.
- The member must undergo careful screening, evaluation, and diagnosis by a multidisciplinary team prior to implantation. This screening must include:
    - Psychological and physical evaluation
    - Psychological and physical evaluation must confirm that the pain is not believed to be of psychological origin
    - Documented evidence of pathology of the chronic pain (an objective basis)

  Except in unusual situations, the diagnosis should be either failed back surgery syndrome or complex regional pain syndrome.
- There is documentation that the pain interferes with a member's daily living activities.

For dorsal column stimulator surgery PA approval, the following criteria must be met:

- The member must complete a trial period of at least three days per the guidelines listed above for the temporarily implanted dorsal column stimulator electrodes for trial purposes.
- The member must demonstrate at least a 50% reduction of pain with a temporarily implanted electrode.
- The results of the trial period must be documented in the PA attachments.

Topic #21318

Gender-Affirming Medical and Surgical Treatment

ForwardHealth covers GAMASTs (gender-affirming medical and/or surgical treatments) for individuals who may identify as, but are not limited to:

- Male
- Female
- Gender diverse
- Nonbinary
- Agender
- Intersex
- Eunuch

ForwardHealth covers GAMASTs with an approved PA (prior authorization) request. Refer to the Pharmacy Resources page for further details regarding PA coverage criteria for gender-affirming hormone therapy. ForwardHealth reviews PA requests for GAMASTs on a case-by-case basis in accordance with federal regulations, including those found in Section 1557 of the Affordable Care Act and in accordance with medical necessity as defined in Wis. Admin. Code § DHS 101.03(96m) and best practices.

When submitting a PA request for GAMASTs, providers must include:

- A completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026))
- A completed PA/PA (Prior Authorization/Physician Attachment, F-11016 (07/2012))
- Clinical records from the member's treating mental health professional that indicate the following:
  - A transgender-related diagnosis
  - The member's personal level of distress and impact on the member's employability, and/or daily functioning over time, relating to the diagnosis
  - The anticipated impact of the requested surgery on the member's level of distress, employability, and/or daily functioning over time.
  - The current status and stability of any coexisting mental health conditions
- Clinical documentation substantiating the requirements detailed in the coverage criteria for the requested procedure

Documentation that the provider requesting the surgery has comprehensively discussed the requested service with the member must be retained in the member's medical file. The documentation must show that the member fully understands all relevant aspects of the requested treatment, including both possible benefits and risks. This documentation is not required to be submitted with the PA request.

Topic #16997

Genetic Testing

When submitting a PA (prior authorization) request for genetic testing, providers are required to submit both the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) and the PA/PA (Prior Authorization/Physician Attachment, F-11016 (07/2012)). The maximum allowable fee schedule indicates which genetic testing services require PA.

For services requiring PA, in situations where published guidelines are not available or are inconclusive, Wisconsin Medicaid and BadgerCare Plus will request that additional information be provided with the PA request, such as peer-reviewed journal articles or published studies, as evidence of the medical necessity of a particular test.

Topic #12377

Gynecomastia Surgery

All gynecomastia procedures require PA (prior authorization). A gynecomastia procedure that does not meet the PA approval criteria is considered noncovered. Any charges related to the noncovered gynecomastia procedure will not be reimbursed.

All of the following must be included as part of a PA request for gynecomastia surgery:

- A completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026))
- A completed PA/PA (Prior Authorization/Physician Attachment, F-11016 (07/2012))
- Documentation supporting the PA approval criteria

Prior Authorization Policy

PA requests for gynecomastia surgery may be approved under Wis. Admin. Code § DHS 107.06(2)(c), which states PA is required for "surgical or medical procedures of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed to significantly interfere with a recipient's personal or social adjustment or employability, an example of which is cosmetic surgery."

Note: Surgical removal of excess male breast tissue is rarely indicated and is usually for cosmetic reasons as there is no functional impairment associated with this disorder.

Prior Authorization Approval Criteria

Prior authorization requests for gynecomastia surgery must include **one** of the following:

- Documentation that the member has a diagnosis of Klinefelter's syndrome
- Documentation that the member is 18 years of age or older, has completed puberty, and meets **all** of the following criteria:
  - Gynecomastia has persisted for at least one year after puberty and is documented in the physician progress notes.
  - The member has persistent breast pain and tenderness.
  - Glandular breast tissue confirming true gynecomastia is documented on physical exam and/or mammography.
  - The member has been evaluated and other hormonal causes of gynecomastia have been excluded by appropriate laboratory testing (TSH, estradiol, prolactin, testosterone, and/or luteinizing hormone).
  - The symptoms have not resolved after discontinuing for at least one year any drugs that may result in gynecomastia.
  - The gynecomastia persists despite treatment of other conditions that may result in gynecomastia.
  - Gynecomastia is classified as a Grade II, III, or IV per the American Society of Plastic Surgeons classification.*

* American Society of Plastic Surgeons scale adapted from the McKinney and Simon, Hoffman and Khan scales:

- Grade II (Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest)
- Grade III (Moderate breast enlargement exceeding areola boundaries with edges that are distinct from the chest with skin redundancy present)
- Grade IV (Marked breast enlargement with skin redundancy and feminization of the breast)

Topic #18577

Hyperbaric Oxygen Therapy

ForwardHealth requires PA (prior authorization) for HBOT (hyperbaric oxygen therapy) provided in an office or outpatient hospital. PA requests for HBOT are required to be submitted with the professional procedure code 99183 (Physician or other qualified healthcare professional attendance and supervision of hyperbaric oxygen therapy, per session).

ForwardHealth does not require PA for HBOT provided in an inpatient hospital setting.

PA Approval Criteria

ForwardHealth covers HBOT for these conditions:

- Acute carbon monoxide intoxication.
- Decompression illness.
- Gas embolism.
- Gas gangrene.
- Acute traumatic peripheral ischemia.
- Crush injuries and suturing of severed limbs.
- Progressive necrotizing infections (necrotizing fasciitis).

- Acute peripheral arterial insufficiency (compartment syndrome).
- Preparation and preservation of compromised skin grafts (not for primary management of wounds).
- Chronic refractory osteomyelitis unresponsive to conventional medical and surgical management.
- Osteoradionecrosis as an adjunct to conventional treatment.
- Soft tissue radionecrosis as an adjunct to conventional treatment.
- Cyanide poisoning.
- Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment. HBOT must be utilized as an adjunct to conventional therapy.
- Treatment of diabetic wounds of the lower extremities. (Refer to the following section for specific approval criteria.)

Approval Criteria for Diabetic Wounds

Clinical criteria for approval of a PA request for HBOT for a member with diabetic wounds of the lower extremities are all of the following:

- Member has Type 1 or Type 2 diabetes and has a lower extremity wound that is due to diabetes.
- Member has a non-pressure wound classified as Wagner grade 3 or higher:
  - Grade 2 — ulcer penetrates to tendon, bone or joint.
  - Grade 3 — lesion has penetrated as deeply as grade 2 and there is abscess, osteomyelitis, pyarthrosis, plantar space abscess, or infection of the tendon and tendon sheaths.
  - Grade 4 — gangrene of the forefoot.
  - Grade 5 — gangrene of the entire foot.
- Member has failed an adequate course of standard wound therapy. The use of HBOT will be covered as adjunctive therapy only after there have been no measurable signs of healing for at least 30 days of treatment with standard wound therapy and only when the use of HBOT is in addition to standard wound care. Standard wound care in members with diabetic wounds includes:
  - Assessment of a member's vascular status and correction of any vascular problems in the affected limb if possible.
  - Optimization of nutritional status.
  - Optimization of glucose control.
  - Debridement by any means to remove devitalized tissue.
  - Maintenance of clean, moist bed of granulation tissue with appropriate moist dressings.
  - Appropriate off-loading.
  - Necessary treatment to resolve any infection that might be present.

Failure to respond to standard wound care means there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBOT. ForwardHealth does not cover continued treatment with HBOT if no measurable signs of healing have been demonstrated within any 30-day period of treatment.

Documentation Requirements

All of the following must be included as part of a PA request for HBOT:

- A completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026))
- A completed PA/PA (Prior Authorization/Physician Attachment, F-11018 (07/12))
- Documentation supporting the criteria in the PA Approval Criteria section
- Documentation indicating that the member has failed an adequate course of standard therapy, including conventional medical or surgical management

Submission Options

Providers may submit PA requests for HBOT via any of the following:

- Portal
- Fax
- Mail
- 278 Health Care Services Review — Request for Review and Response Transaction

Topic #16818

Intrathecal Infusion Pumps for Spasticity or Pain

Placement of IIP (intrathecal infusion pumps) for treatment of spasticity or pain is covered by ForwardHealth with PA (prior authorization).

Intrathecal Infusion Pumps for Treatment of Spasticity

Screening Dose and Permanent Implantation

ForwardHealth allows providers to submit one PA request for the permanent implantation of the IIP for the treatment of spasticity. Although separate approval of a successful trial period is not required for approval of the PA request for permanent implantation, providers are required to maintain documentation of a successful screening dose in their records. Permanent implantation of an IIP is not reimbursable without a successful screening dose.

ForwardHealth covers a temporary baclofen bolus screening dose and permanent baclofen IIP implantation for the treatment of spasticity when all of the following criteria are met and documented in the PA request:

- The member suffers from chronic, intractable spasticity.
- All other appropriate treatment methods (pharmacological [including failure of oral baclofen in adults], surgical, and physical therapies) have been given an adequate trial period and proved unsatisfactory or were judged to be unsuitable or contraindicated for the member.
- The spasticity interferes with a member's daily living activities.

Note: The approved PA request for permanent implantation of the IIP will not be valid unless a successful screening dose shows at least a 50% reduction of spasticity.

Requests for PA for baclofen pump implantation will be denied by ForwardHealth for the following members:

- Members who are allergic to baclofen.
- Members with the presence of an infection at the time of either the screening dose or permanent pump placement.
- Members whose body size is too small to accommodate the implantable pump.
- Members who have an inability to comply with therapy maintenance (refills).
- Members who are younger than 4 years old.

Intrathecal Infusion Pumps for Treatment of Pain

Trial Period

ForwardHealth covers a trial period of intraspinal opioid drug administration lasting a minimum of 24 hours for the treatment of pain when all of the following criteria are met and documented as part of the PA request:

- The member has not responded adequately to non-invasive methods of pain control.
- Other treatment methods (pharmacological, surgical, physical, or psychological therapies) have been given an adequate trial period and proved unsatisfactory or were judged to be unsuitable or contraindicated for the member.

- The member has undergone careful screening by a multidisciplinary team prior to the beginning of the trial drug administration. That screening must include both a psychological and physical evaluation. These evaluations must confirm that the pain is not believed to be primarily psychological in origin and should reflect clear evidence of a physiological explanation for the chronic pain (for example, an objective basis, such as an imaging study showing pathology consistent with the clinical complaints and of sufficient severity to explain symptoms).

Permanent Implantation

PA is required for implantation of an IIP for the treatment of pain.

ForwardHealth covers permanent IIP implantation for the treatment of pain when all of the following criteria are met and documented in the PA request:

- An authorized trial period lasting a minimum of 24 hours has been completed. Trial period authorization criteria are listed above.
- There is at least a 50% reduction in pain during the trial.
- A record of any side effects that the member experiences.

ForwardHealth will consider exceptions to the above requirements in the situations of terminal care for cancer with uncontrollable pain. ForwardHealth will review these requests on an individual basis, and a trial period is not required.

Note: Requests for PA for IIP implantation for the treatment of pain will be denied by ForwardHealth for members in the following circumstances:

- Members who have a known allergy or hypersensitivity to the drug being used.
- Members with the presence of an active infection.
- Members whose body size is too small to accommodate the implantable pump.
- Members with the presence of spinal anomalies.
- Members who have an inability to comply with therapy maintenance (refills).
- Members who are younger than 4 years old.

Topic #16497

Panniculectomy and Lipectomy Surgeries

Panniculectomy and lipectomy surgeries are covered by ForwardHealth with PA (prior authorization).

Panniculectomy surgery is considered medically necessary if the panniculus hangs below the level of the pubis **and** either one of the following criteria is met:

- The medical record documents that the panniculus causes chronic intertrigo that is refractory to at least three months of appropriate medical therapy or consistently recurs over three months while receiving appropriate medical therapy.
- There is a presence of a significant functional deficit that prohibits or profoundly impairs the ability to perform activities of daily living due to a significant physical deformity or disfigurement resulting from the excess skin folds, and surgery is expected to restore or greatly improve the functional deficit. Examples of this would be deficits that prohibit a member from being able to properly shower or toilet.

Lipectomy surgery is considered medically necessary if at least one of the following criteria is met:

- The medical record documents that the excess skin folds cause a chronic intertrigo that is refractory to at least three months of appropriate medical therapy or consistently recurs over three months while receiving appropriate medical therapy.
- There is a presence of a significant functional deficit that prohibits or profoundly impairs the ability to perform activities of

daily living due to a significant physical deformity or disfigurement resulting from the excess skin folds, and surgery is expected to restore or greatly improve the functional deficit. Examples of this would be deficits that prohibit a member from being able to properly shower or toilet.

Note: If the procedure is being performed following significant weight loss, in addition to meeting the PA criteria, there should be evidence documented in the member's medical records that the individual has maintained a stable weight for at least six months. If the weight loss is the result of bariatric surgery, panniculectomy should not be performed until at least 18 months after bariatric surgery and only when weight has been stable for at least the most recent six months.

Information regarding PA criteria for bariatric surgeries is available.

Panniculectomy for any other indication is not covered, including the following:

- Treatment of back, knee, or neck pain
- In conjunction with hernia repair, unless the member meets the above-stated criteria for panniculectomy

Topic #12417

Pectus Excavatum or Pectus Carinatum Surgery

All pectus excavatum and pectus carinatum procedures require PA (prior authorization). A pectus excavatum or pectus carinatum procedure that does not meet the PA approval criteria is considered a noncovered service. Any charges related to the noncovered pectus excavatum or pectus carinatum procedure will not be reimbursed.

Prior Authorization Policy

Congenital chest wall deformities may result in functional limitations such as activity intolerance related to cardiac or respiratory impairment. Patients often report symptoms that include mild to moderate exercise limitation, respiratory infections, and asthmatic conditions. In many cases, the deformity does not lead to functional impairment, and treatment is considered to be solely cosmetic in nature.

PA requests for pectus excavatum or pectus carinatum surgery may be approved under Wis. Admin. Code § DHS 107.06(2)(c), which states PA is required for "surgical or medical procedures of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed to significantly interfere with a recipient's personal or social adjustment or employability, an example of which is cosmetic surgery."

Prior Authorization Approval Criteria for Pectus Excavatum

Any one of the following criteria must be met for PA requests for repair of severe pectus excavatum when the pectus index (for example, Haller index *) is greater than 3.25:

- Pulmonary function studies demonstrate at least moderately severe restrictive airway disease.
- Echocardiograph demonstrates finding consistent with external compression.
- Abnormal cardiovascular or ventilator limitation is evident during cardiopulmonary exercise testing.
- Documentation of progression of the deformity with associated physical symptoms other than isolated concerns of body image.

* The degree of deformity can be determined by dividing the inner width of the chest at the widest point by the distance between the posterior surface of the sternum and the anterior surface of the spine. CT scans are better able to define the ratio of AP (anterior-posterior) borders to transverse diameters, also referred to as the pectus index or Haller index. Diameters are taken at the deepest level of the sternal depression. CT scan ratios that reveal transverse to AP diameter of greater than 3.25 are

considered significant for pectus excavatum. A normal chest has an index of 2.5.

Prior Authorization Approval Criteria for Pectus Carinatum

PA requests for pectus carinatum surgical procedures are subject to the following PA guidelines:

- The member must have a diagnosis of pectus carinatum.
- Surgical correction of pectus carinatum may be approved in severe cases with cardiopulmonary compromise (frequently associated with another deformity; for example, scoliosis) if both of the following criteria are met:
  - Pulmonary function tests document the obstructive abnormalities (Note: Pectus carinatum is generally not associated with restrictive abnormalities).
  - A chest X-ray demonstrates an increased anteroposterior diameter of the chest wall, emphysematous-appearing lungs, and a narrow cardiac shadow; or echocardiography demonstrates a deformity of the cardiac silhouette (Note: Malposition of the cardiac silhouette in the absence of a study demonstrating reduced cardiac function is not, in itself, a functional deficit).

Topic #19138

Prophylactic Mastectomy

All prophylactic mastectomies require PA (prior authorization). A prophylactic mastectomy that does not meet the PA approval criteria is considered noncovered. Any claims submitted for a noncovered prophylactic mastectomy will not be reimbursed.

All of the following must be included as part of a PA request for prophylactic mastectomy:

- A completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026))
- A completed PA/PA (Prior Authorization/Physician Attachment, F-11016 (07/2012))
- Documentation supporting the PA approval criteria

Prior Authorization Approval Criteria for Members Considered High Risk for Breast Cancer Without a Diagnosis, or History of a Diagnosis, of Breast Cancer

PA requests for a prophylactic mastectomy for members considered high risk for breast cancer **without** a diagnosis, or history of a diagnosis, of breast cancer may be approved when **one or more** of the following criteria are met:

- There is a presence of a known BRCA1, BRCA2, PTEN, or TP53 mutation.
- The member received radiation therapy to the chest between the ages of 10 and 30 (for example, for Hodgkin disease).
- The member has a lifetime risk of breast cancer of 20% or greater as identified by Gail, Claus, BRCAPRO, BOADICEA, Tyrer-Cuzick models.
- There is a presence of high-risk histology or of extensive mammographic abnormalities.

  High-risk histology includes atypical ductal or lobular hyperplasia, or lobular carcinoma in situ confirmed on biopsy. In cases of high-risk histology, prophylactic mastectomy may be considered medically necessary, especially if combined with other risk factors (for example, family history of breast cancer, proof of mammographic or clinical evaluation difficulty).

  Extensive mammographic abnormalities include diffuse indeterminate microcalcifications or dense tissue that is difficult to evaluate mammographically and clinically, making adequate biopsy impossible. In cases of extensive mammographic abnormalities, prophylactic mastectomy may be considered medically necessary, especially if combined with other evidence of risk factors (for example, dense, fibronodular breasts, several prior breast biopsies for clinical and/or mammographic

abnormalities).

Prior Authorization Approval Criteria for Members Considered High Risk for Breast Cancer With a Diagnosis, or History of a Diagnosis, of Breast Cancer

PA requests for a prophylactic mastectomy for members considered high risk for breast cancer **with** a diagnosis, or history of a diagnosis, of breast cancer may be approved when **one or more** of the following criteria are met:

- The member is at high risk for contralateral disease due to any of the criteria listed above for members without a diagnosis, or history of a diagnosis, of breast cancer.
- The member was diagnosed with breast cancer at the age of 45 or younger.
- The member is male and has breast cancer.

Prophylactic mastectomy is considered experimental and investigational for men with BRCA or other gene mutations, or with a family history of breast cancer without diagnosis, or history of a diagnosis, of breast cancer.

Topic #18277

Reduction Mammoplasty

Reduction mammoplasty for female members with breast hypertrophy (enlarged breasts) is covered by ForwardHealth with PA. (prior authorization)

Prior Authorization Approval Criteria

At least one of this criteria must be met for PA requests to be approved for reduction mammoplasty:

- The member has persistent symptoms in at least two of the following anatomical body areas affecting daily activities for at least one year:
  - Headaches
  - Pain in neck
  - Pain in shoulders
  - Pain in upper back
  - Painful kyphosis documented by X-rays
- The member has severe submammary intertrigo that is refractory to conventional medications and measures used to treat intertrigo, or the member has shoulder grooving with ulceration unresponsive to conventional therapy.

In addition, all of this criteria must be met for PA requests to be approved for reduction mammoplasty:

- There is documentation from a primary care physician and other providers, as appropriate (for example, physiatrist, orthopedic surgeon) showing the diagnosis and evaluation of symptoms that prompted this request, which confirms that the following criteria have been met:
  - There is a reasonable likelihood that the member's symptoms are primarily due to macromastia.
  - Reduction mammoplasty is likely to result in improvement of the chronic pain.
  - Pain symptoms persist, as documented by the physician, despite at least a three-month trial of therapeutic measures such as:
    - Analgesic/NSAIDs (non-steroidal anti-inflammatory drugs) interventions
    - Physical therapy/exercises/posturing maneuvers
    - Supportive devices (for example, proper bra support, wide bra straps)

- If the woman is 40 years of age or older, she has had a negative (for cancer) mammogram that was performed within the year prior to the date of the planned reduction mammoplasty.
- The surgeon has estimated the amount (in grams) of breast tissue (not fatty tissue) to be removed from each breast and that amount meets the medical necessity criteria determined using the Schnur Sliding Scale chart calculations as shown below.

Body Surface Area Formulas
BSA (m^2) = ([height (in) x weight (lb)]/3131)½
BSA (m^2) = ([height (cm) x weight (kg)]/3600)½

Schnur Sliding Scale	
Body Surface Area	**Threshold Value for the Average Grams of Tissue per Breast to Be Removed**
1.35	199
1.40	218
1.45	238
1.50	260
1.55	284
1.60	310
1.65	338
1.70	370
1.75	404
1.80	441
1.85	482
1.90	527
1.95	575
2.00	628
2.05	687
2.10	750
2.15	819
2.20	895
2.25	978
2.30	1068
2.35	1167
2.40	1275
2.45	1393
2.50	1522
2.55	1662

Chronic intertrigo, eczema, dermatitis, and/or ulceration in the infra-mammary fold are not necessarily considered medically necessary indications for reduction mammoplasty. In order to be considered medically necessary, the condition must be severe

and unresponsive to dermatological treatments (for example, antibiotics or antifungal therapy) and conservative measures (for example, good skin hygiene, adequate nutrition) for a period of six months or longer.

Prior Authorization Request Documentation Requirements

This must be documented on the PA request:

- Height and weight of the member
- Approximate amount of tissue (in grams) to be removed from each breast

When requesting PA, submission of photographic documentation that confirms severe breast hypertrophy is not required but must be available upon request.

Approved PA requests for reduction mammoplasty are valid for 12 months.

Note: For male members with excess breast tissue, ForwardHealth covers mastectomy for gynecomastia when medically necessary per Wis. Admin. Code § DHS 101.03(96m); however, PA is required.

Topic #13797

Restorative Plastic Surgery and Procedures

PA (Prior authorization) requests for restorative plastic surgery and procedures must meet one of the following criteria:

- Documentation that supports medical necessity for the procedure included in the PA request (for example, signs and symptoms such as pain, repeated trauma to lesion, recurrent infection)
- Detailed documentation of a congenital defect, birth abnormality, or other significant defect
- A psychiatric evaluation documenting the procedure's necessity based on significant impairment of the member's social or personal adjustment
- Documentation of significant impact on the member's employability, including documentation that there are no other irresolvable factors that would prevent the member from being employed (Documented attempts at employment or other clear supporting evidence should be included with the PA request.)

When requesting PA, a photograph of the involved area is desirable but not mandatory.

Restorative plastic surgeries and procedures that do not meet the PA approval criteria are considered noncovered services. Any claims submitted for noncovered restorative plastic surgeries and procedures will not be reimbursed.

Topic #13757

Vagus Nerve Stimulator Implant Surgeries

The following criteria must be met for PA (prior authorization) requests to be approved for VNS (vagus nerve stimulator) implant surgery:

- The member has either medically intractable partial-onset seizures for which resective or disconnection epilepsy surgery is either not an option (for personal or medical reasons) or has failed; or the member has medically intractable primary generalized, symptomatic generalized, or mixed epilepsy.
- Multiple trials of antiepileptic medications with documented compliance have either failed or have produced unacceptable side effects.
- The medical record contains documentation that the member's seizures significantly interfere with daily functioning and

quality of life, and there is reason to believe that quality of life will be improved as a result of VNS.

- The member does not have other, independent diagnoses that could explain why their seizures are failing to respond to medical treatment.

Review Process

Topic #450

Clerical Review

The first step of the PA (prior authorization) request review process is the clerical review. This is an administrative process to verify the provider, member, diagnosis, and treatment information indicated on the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) and PA/DRF (Prior Authorization/Dental Request Form, F-11035 (06/2024)) forms. Examples of information verified during the clerical review include:

- Valid provider and member information.
- All required elements are complete.
- Forms, attachments, and additional supporting clinical documentation are signed and dated.
- A current provider's prescription for the service is attached, if required.

Drug-related PA requests with clerical errors and omissions will be returned to pharmacy providers due to inaccurate or incomplete information. Any inaccurate or incomplete non-drug PA requests will be recorded as Incomplete – PA Denied. 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 or PA/DRF.

Topic #451

Clinical Review

Upon verifying the completeness and accuracy of clerical items, a PA (prior authorization) request is reviewed to evaluate whether or not each service being requested meets Wisconsin Medicaid's definition of "medically necessary," as well as other criteria.

The PA attachment allows a provider to document the clinical information used to determine whether the standards of medical necessity are met for the requested service. Wisconsin Medicaid considers certain factors when determining whether to approve or deny a PA request pursuant to Wis. Admin. Code § DHS 107.02(3)(e).

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 Wis. Admin. Code § DHS 101.03(96m), "medically necessary" is a service under Wis. Admin. Code ch. DHS 107 that meets certain criteria.

Determination of Medical Necessity

The definition of "medically necessary" is a legal definition identifying the standards that must be met for approval of the service. The definition imposes parameters and restrictions that are both medical and nonmedical.

The determination of medical necessity is based on the documentation submitted by the provider. For this reason, it is essential that documentation is submitted completely and accurately and that it provides the justification for the service requested, specific to the member's current condition and needs. To be approved, a PA request must meet all of the standards of medical necessity including those that are not strictly medical in nature.

To determine if a requested service is medically necessary, ForwardHealth consultants obtain direction and/or guidance from multiple resources including:

- Federal and state statutes
- Wisconsin Administrative Code
- PA guidelines set forth by Wisconsin DHS (Department of Health Services)
- Standards of practice
- Professional knowledge
- Scientific literature

Services Requiring Prior Authorization

Topic #1004

An Overview

Physician services that require PA (prior authorization) are subject to change and are periodically updated by ForwardHealth. General services requiring PA include the following:

- All covered physician services if provided out-of-state under nonemergency circumstances by a provider who does not have border-status enrollment with Wisconsin Medicaid.
- Surgical or other medical procedures of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed to significantly interfere with a member's personal or social adjustment or employability.

Contact a Medicaid-enrolled pharmacist or Provider Services for information regarding possible PA or diagnosis restrictions for a particular drug.

Audiological Testing for Hearing Instruments

A PA/POR (Prior Authorization/Physician Otological Report, F-11019 (07/2012)) is required for audiological testing for specifications of a hearing instrument. A photocopy of the approved hearing instrument PA request form is sent to the member who presents it to the Medicaid-enrolled audiologist or hearing instrument specialist of his or her choice.

Bariatric Surgery

Approval criteria for bariatric surgery, revision of bariatric surgery, and repeat bariatric surgery are available.

Reduction Mammoplasty

Approval criteria for reduction mammoplasty are available.

Dorsal Column or Spinal Stimulator Surgeries

Approval criteria for dorsal column or spinal stimulator surgeries are available.

Gynecomastia Surgery

Approval criteria for gynecomastia surgery are available.

Hyperbaric Oxygen Therapy

Approval criteria for HBOT (hyperbaric oxygen therapy) are available. HBOT provided in an office or outpatient hospital requires PA.

Infertility and Impotence Services

Treatment of infertility and impotence are noncovered services under ForwardHealth. 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.

Intrathecal Infusion Pumps for Spasticity or Pain

Approval criteria for placement of IIP (intrathecal infusion pumps) for the treatment of spasticity or pain are available.

Panniculectomy and Lipectomy Surgeries

Approval criteria for panniculectomy and lipectomy surgeries are available.

Pectus Excavatum or Pectus Carinatum Surgery

Approval criteria for pectus excavatum or pectus carinatum surgery are available.

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 (for example, to support a penile catheter). Replacement of an inflatable penile prosthesis is not a covered service.

Prophylactic Mastectomy

Approval criteria for prophylactic mastectomy are available.

Transplant Services

The hospital, rather than the physician, is responsible for obtaining PA for transplant services that require PA. Physicians should make sure all necessary approvals have been obtained by the hospital before proceeding with a transplant operation. ForwardHealth does not require PA for collection of the donor organ.

Restorative Plastic Surgery and Procedures

Approval criteria for restorative plastic surgery and procedures are available.

Subcutaneous Cardiac Rhythm Monitors

The insertion of subcutaneous cardiac rhythm monitors, including programming, is covered by ForwardHealth with an approved PA request.

Vaginal Construction

Vaginal construction (procedure codes 57291 and 57292) may be approved through PA for correction of a congenital defect surgery or GAMASTs (gender-affirming medical and/or surgical treatments). Approval criteria for GAMASTs are available.

Vagus Nerve Stimulator Implant Surgeries

Approval criteria for vagus nerve stimulator implant surgeries are available.

Weight Management Services

All medical services (beyond five E&M (evaluation and management) office visits per calendar year) aimed specifically at weight management and procedures to reverse such services require PA.

Topic #12177

Bariatric Surgery

All covered bariatric surgery procedures require PA (prior authorization). A bariatric procedure that does not meet the following PA approval criteria is considered a noncovered service.

Prior Authorization Approval Criteria for Bariatric Surgery

PA requests for bariatric surgery may be approved if **one** of the following criteria is met:

- The member has a BMI (body mass index) greater than or equal to 35 kg/m^2 and inadequately controlled Type 2 diabetes mellitus despite appropriate therapy with at least two medications of different drug classes, either oral or injectable.
- The member has a BMI greater than or equal to 40 kg/m^2 and **one** of the following:
  - Moderate to severe obstructive sleep apnea
  - Type 2 diabetes mellitus
  - Medically refractory hypertension (blood pressure consistently greater than 140/90 mmHg despite the concurrent use of three anti-hypertensive agents of different drug classes)
  - Obesity-related cardiomyopathy
  - Pickwickian syndrome (obesity hypoventilation syndrome)
- The member has a BMI greater than or equal to 50 kg/m^2 and mechanical arthropathy with documented functional impairment by a licensed physical therapist.

In addition to one of the above criteria, the member is required to meet **all** of the following criteria:

- The member is 18 years of age or older.
- The member has been obese for at least five years.
- Adequate prior attempts to lose weight or maintain weight loss have failed, **or,** for members whose prior attempts at weight loss have been deemed absent or inadequate, a six-month medically supervised weight loss program has been undertaken.

  Note: An acceptable medically supervised weight loss program is weight loss guidance that is provided in a clinical setting by a licensed healthcare professional on repeated occasions over at least a six-month period.

  These required weight loss attempts by the member are prior to and separate from the bariatric assessment and six-month multi-disciplinary surgical preparatory regimen described below.

- The member has been determined to be an appropriate surgical candidate based on an evaluation by the PCP (primary care provider) or other appropriate provider (for example, the member does not have cardiopulmonary disease that would make surgical risk prohibitive or other identifiable contraindication to elective surgery).
- The member has abstained from alcohol abuse and other substance abuse for at least six months.
- The member has undergone a multidisciplinary bariatric team assessment within 12 months of the proposed surgery and has been found by consensus to be an appropriate surgical candidate, and there is documentation that supports that the member understands risks, benefits, expected outcomes, alternatives, and required lifestyle changes. The bariatric assessment, at a minimum, must include the following:
  - The member's medical history, physical exam results, and proposed plan by the bariatric surgeon
  - A psychological or psychiatric evaluation to determine readiness for surgery and identify any mental health barriers to the success of the proposed surgery. If a comorbid psychiatric diagnosis exists, an assessment of adequate stability

must come from the treating mental health provider.
    - At least six consecutive months of documented participation and progress in a multi-disciplinary surgical preparatory regimen that includes dietary counselling, supervised exercise, and behavior modification to assess the member's ability to comply with the necessary post-operative lifestyle changes and to signal surgical readiness. Records must document member compliance with this multidisciplinary surgical preparatory regimen. Accordingly, the member must not have a net weight gain during this period greater than what is explainable as a normal fluctuation (up to five pounds) or otherwise attributable to a recognized medical condition (such as edema). If applicable, members should be strongly encouraged to stop smoking preoperatively.
- The member has been evaluated for and does not have a contributing endocrinopathy.

Note: Bariatric surgery is not required to be performed at an American Society for Metabolic and Bariatric Surgery-certified Center of Excellence or Level 1 Bariatric Surgery Center; however, centers and teams performing bariatric surgery must be experienced in the management of metabolic surgery and obesity-related comorbidities.

Prior Authorization Approval Criteria for Revision of Bariatric Surgery

PA requests for revision of bariatric surgery may be approved if **one** of the following criteria is met:

- Removal of a gastric band is considered medically necessary and is recommended by the member's physician.
- Surgery to correct complications of a prior bariatric surgery is considered medically necessary for such issues as obstruction, stricture, erosion, band slippage, or port or tubing malfunction.

Note: Revision of a primary bariatric surgery procedure that has failed (for example, surgery was initially successful at inducing weight loss, then the member regained weight) due to dilation of the gastric pouch, a dilated gastrojejunal stoma, or dilatation of the gastrojejunostomy anastomosis is not covered if, as in most cases of dilation, the primary cause for these remote post-surgical changes is noncompliance (for example, overeating).

Prior Authorization Approval Criteria for Repeat Bariatric Surgery

PA requests for repeat bariatric surgery may be approved for members whose initial bariatric surgery was considered medically necessary and who meet **one** of the following medical necessity criteria:

- Replacement of an adjustable band is considered medically necessary because there are complications (for example, port leakage or slippage) that cannot be corrected with band manipulation or adjustments.
- Conversion from an adjustable band to a sleeve gastrectomy, Roux-en-Y gastric bypass, or biliopancreatic diversion with duodenal switch is considered medically necessary for a member who has been compliant with a prescribed nutrition and exercise program following the band procedure but who has complications that cannot be corrected with band manipulation, adjustments, or replacement.

Prior Authorization Documentation

When requesting PA for bariatric surgery, revision of bariatric surgery, or repeat bariatric surgery, providers are required to submit **all** of the following:

- A completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026))
- A completed PA/PA (Prior Authorization/Physician Attachment, F-11016 (07/2012))
- Documentation that fully supports the approval criteria

Length of Authorization

The length of authorization for an approved PA request for bariatric surgery, revision of bariatric surgery, or repeat bariatric

surgery is 12 months.

Topic #18137

Bone Growth Stimulators

Bone growth stimulators are covered by ForwardHealth with PA (prior authorization). Bone growth stimulators are considered Class III medical devices by the FDA (Food and Drug Administration). PA requests for these devices may be approved if they are medically necessary and are employed for a qualifying FDA-approved use.

Approval Criteria for Electrical Bone Growth Stimulators

Documentation of at least one of the following clinical criteria must be submitted for PA approval of an electrical bone growth stimulator using HCPCS (Healthcare Common Procedure Coding System) procedure code E0747 (Osteogenesis stimulator, electrical, non-invasive, other than spinal applications):

- A nonunion fracture of bones of the appendicular skeleton (clavicle, humerus, radius, ulna, femur, fibula, tibia, carpal, metacarpal, tarsal, or metatarsal) demonstrating three or more months of ceased healing. Serial radiographs must include two sets of radiographs, each with multiple views of the fracture site and separated by a minimum of 90 days.
- A failed fusion of a joint where a minimum of nine months has lapsed since the last surgery.
- Congenital pseudarthrosis.

Documentation of at least one of the following clinical criteria must be submitted for PA approval of an electrical bone growth stimulator using HCPCS procedure code E0748 (Osteogenesis stimulator, electrical, non-invasive, spinal applications):

- Spinal fusion surgery for members with a history of previously failed spinal fusion at the same site
- Multiple level fusion surgery involving three or more vertebrae (for example, L3-L5, L4-S1)
- A failed fusion where a minimum of nine months has lapsed since the last surgery

Approval Criteria for Ultrasonic Bone Growth Stimulator

Documentation supporting the use of an ultrasonic bone growth stimulator for the treatment of nonunion fracture of bones of the appendicular skeleton (clavicle, humerus, radius, ulna, femur, fibula, tibia, carpal, metacarpal, tarsal, or metatarsal) must be submitted for PA approval of an ultrasonic bone growth stimulator using HCPCS procedure code E0760 (Osteogenesis stimulator, low intensity ultrasound, non-invasive). Nonunion fractures must be documented by a minimum of two sets of radiographs (with multiple views) obtained prior to starting treatment and separated by a minimum of 90 days.

Prior Authorization Documentation

All of the following must be included as part of a PA request for a bone growth stimulator:

- A PA/RF (Prior Authorization Request Form, F-11018 (04/2026)), completed by the DME vendor
- A PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (02/2024)), completed by the physician
- Documentation supporting the clinical criteria indicated above
- A prescription

Topic #18057

Bone-Anchored Hearing Device Repairs and

Replacements

HCPCS (Healthcare Common Procedure Coding System) procedure codes L7510 (Repair of prosthetic device, repair or replace minor parts) and L8691 (Auditory osseointegrated device, external sound processor excludes transducer/actuator; replacement only, each) are allowable for repairs and replacements of bone-anchored hearing devices.

PA (prior authorization) is required for procedure code L7510 if the total repair of the bone-anchored hearing device exceeds $150.00 or if the replacement parts of the bone-anchored hearing device have not exceeded their life expectancy.

PA is not required for procedure code L8691.

Note: ForwardHealth assigns U modifiers to multiple items listed on PA requests to indicate separate approval of DME (durable medical equipment) items (such as, accessories).

Topic #23658

Casgevy

Clinical PA (prior authorization) is required for Casgevy.

If a PA request for Casgevy is approved, Casgevy will be covered under the pharmacy benefit. To bill ForwardHealth for Casgevy, pharmacy providers should submit a pharmacy noncompound drug claim and include the member's diagnosis code on the pharmacy claim submitted for Casgevy. The DOS (date of service) submitted on the pharmacy claim must be the date the member received the infusion of Casgevy.

For specific questions about the billing or coverage of high cost, orphan, and accelerated approval drugs, providers may contact Provider Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

Casgevy Cell and Gene Therapy Access Model Requirements for Treatment Centers

Casgevy is a State-Selected Model Drug in the CMS' (Centers for Medicare & Medicaid Services') CGT (Cell and Gene Therapy) Access Model when used for the treatment of SCD (sickle cell disease). Casgevy used for β-thalassemia is **not** included in the CGT Access Model at this time.

The treatment center must agree to all of the following for members determined to be eligible in the CGT Access Model:

- Treatment center providers administering Casgevy for SCD must enroll and participate in the CMS-Designated Patient Registry through CIBMTR (Center for International Blood and Marrow Transplant Research).
- Treatment center providers must be enrolled in CIBMTR before administering Casgevy to Wisconsin Medicaid members.
- Treatment center providers must also obtain member consent to participate in the CIBMTR Research Database Protocol under which this study will be governed and are responsible for submitting data to CIBMTR, per the CGT Access Model study requirements.
- Treatment center providers administering Casgevy for SCD must ensure Casgevy is not purchased through the 340B Drug Pricing Program (340B Program) when administered to eligible CGT Access Model members.

For assistance with enrollment in the CMS-Designated Patient Registry for the CMS CGT Access Model, providers may email CIBMTR at CGTModel@mcw.edu.

Requirements for Casgevy

Casgevy will be reimbursed separately from physician and clinical services associated with the administration of Casgevy. The pharmacy provider is required to establish a delivery process with the prescriber to ensure that the physician-administered Casgevy is delivered directly to the administering treatment center.

Pharmacy providers may only submit a claim to ForwardHealth for Casgevy that has been administered to a member. If Casgevy has been dispensed for a member but the dose is not administered to the member, the prescriber is responsible for notifying the dispensing pharmacy. If ForwardHealth has paid the dispensing pharmacy for any portion of the dispensing of Casgevy that is not administered to the member, the dispensing pharmacy is responsible for reversing any claims submitted to ForwardHealth.

Casgevy must be prescribed at a minimum recommended dose of 3.0×10^6 CD34+ cells/kg of body weight.

The member must have full myeloablative conditioning administered before infusion of Casgevy. Full myeloablative conditioning must be administered between 48 hours and seven days before infusion of Casgevy.

Standard procedures for patient management after HSC (hematopoietic stem cell) transplantation should be followed after Casgevy infusion.

The prescriber must manage other concomitant medications (as applicable) consistent with FDA (Food and Drug Administration) product labeling.

The member must not take disease-modifying therapies (for example, crizanlizumab, hydroxyurea, L-glutamine, voxelotor) for at least two months prior to mobilization.

The member must not take iron chelation therapy at least seven days prior to myeloablative conditioning. The member must not take non-myelosuppressive iron chelators for at least three months and myelosuppressive iron chelators for at least six months after Casgevy infusion.

Additional Requirement for Casgevy for Sickle Cell Disease Treatment

G-CSF (Granulocyte-Colony Stimulating Factor) must not be used prior to or with mobilization and conditioning.

PA Information for Casgevy

Conditions for Which PA Requests for Casgevy Will Be Considered for Review

ForwardHealth will only consider PA requests for Casgevy for the following clinical conditions:

- β-thalassemia
- SCD

Clinical Criteria for Casgevy for β-Thalassemia

The clinical criteria that must be documented for approval of a PA request for Casgevy for β-thalassemia are **all** of the following:

- Casgevy must be prescribed and administered by a physician and treatment center with expertise in treating β-thalassemia with Casgevy.
- The member has β-thalassemia, which requires regular RBC (red blood cell) transfusions. The member has a history of transfusions for the past two years of at least 100 mL/kg/year of packed RBCs or at least 10 units/year of RBC transfusions in the previous two years.
- The member's age at the time of the planned infusion is consistent with the FDA-approved product labeling for Casgevy.
- The prescriber will provide documentation of completed negative screening for active infectious diseases including HBV

(hepatitis B virus), HCV (hepatitis C virus), HIV 1 and 2 (HIV-1/HIV-2) and HTLV (Human T-lymphotropic virus) 1 and 2 (HTLV-1/HTLV-2), in accordance with clinical guidelines before collection of cells for manufacturing.
- The prescriber has attested that the member is clinically stable and fit for transplantation.

Clinical Criteria for Casgevy for Sickle Cell Disease

The clinical criteria that must be documented for approval of a PA request for Casgevy for SCD are **all** of the following:

- Casgevy must be prescribed and administered by a physician and treatment center with expertise in treating SCD with Casgevy.
- The prescribing provider attests that at least one of the following is true:
  - The member has experienced an unsatisfactory therapeutic response with hydroxyurea.
  - The member has experienced a clinically significant adverse drug reaction with hydroxyurea.
  - There is a clinically significant drug interaction between another drug(s) the member is taking and hydroxyurea.
  - The member has a medical condition(s) that prevents the use of hydroxyurea.
- The prescribing provider attests that the member has SCD with a history of two or more VOEs (vaso-occlusive events) per year within the previous 24 months or is currently receiving chronic transfusion therapy for recurrent VOCs (based on provider attestation).
- The member's age at the time of the planned infusion is consistent with the FDA-approved product labeling for Casgevy.
- The prescriber will provide documentation of completed negative screening for active infectious diseases including HBV, HCV, HIV 1 and 2 (HIV-1/HIV-2), and HTLV 1 and 2 (HTLV-1/HTLV-2) in accordance with clinical guidelines before collection of cells for manufacturing.
- The prescriber has attested that the member is clinically stable and fit for transplantation.

Conditions Not Approved for PA Requests for Casgevy

PA requests for Casgevy for β-thalassemia or SCD **will not** be approved if the member has any of the following conditions:

- Advanced liver disease that, in the opinion of the prescriber, renders the member not clinically fit and stable for transplantation
- A history of untreated Moyamoya disease or the presence of Moyamoya disease that, in the opinion of the prescriber, puts the member at risk of bleeding
- Current malignancy, myeloproliferative disorder, or significant immunodeficiency disorder, unless the prescribing provider attests that the member's condition would not deem the member ineligible for treatment
- Prior allogenic or autologous HSC transplant

Submitting PA Requests for Casegevy

PA requests for Casgevy must be completed, signed, and dated by the prescriber. PA requests for Casgevy must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (01/2024)) form. Clinical documentation supporting the use of Casgevy must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) to ForwardHealth.

PA requests for Casgevy may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

PA requests for Casgevy will be approved for 365 days.

Information is available about general ForwardHealth policy for drugs that require PA approval. This includes what may **not** be considered criteria to support the need for a drug.

Topic #24044

Cell and Gene Therapy Access Model

The Wisconsin DHS (Department of Health Services) is participating in the CMS (Centers for Medicare & Medicaid Services')' CGT (Cell and Gene Therapy) Access Model. This model allows DHS to enter into agreements with the manufacturers of two State-Selected Model Drugs for SCD (sickle cell disease):

- Casgevy
- Lyfgenia

Qualifications for BadgerCare Plus and Medicaid Members' Participation

Certain BadgerCare Plus and Medicaid members' treatment with these drugs will qualify for receiving it through the CGT Access Model. The Model cannot include members eligible under the separate CHIP (Children's Health Insurance Program) portion of Badger Care Plus.

To be eligible, members must:

- Have a documented medical diagnosis of SCD.
- Have Wisconsin Medicaid as the primary payer for a State-Selected Model Drug.
- Have received an infusion of a State-Selected Model Drug.
- Have received that infusion while the CGT Access Model outcome-based agreements between DHS and the drug manufacturers are in effect.

Fertility Preservation

Fertility preservation is **not** a covered BadgerCare Plus or Medicaid benefit. It is only available to members who qualify to receive care through the CGT Access Model, as it is offered through the manufacturers of the drugs they are being treated with. Free fertility preservation services are not available to members with SCD whose treatment does not qualify for participation in the CGT Access Model. Providers should follow the drug manufacturers' guidance regarding referrals for fertility preservation for interested members receiving care through the model.

Managed Care Exemption

BadgerCare Plus and Medicaid members who participate in the CGT Access Model will be permanently exempted from having to be in an HMO once an infusion date has been scheduled, beginning the first of the month of the first round of apheresis. Either the member or the HMO may request exemption through a DHS nurse consultant. Appropriate documentation showing an approved PA (prior authorization) and scheduled infusion date must accompany the exemption request.

Non-Emergency Medical Transportation

Transportation for any SCD-related appointments is considered a **critical care** ride. Critical care rides can be scheduled up to the same day as the appointment, and they are eligible for additional support from NEMT (Non-Emergency Medical Transportation) call center representatives, who can help schedule and coordinate rides. When members schedule rides, they must tell the agent that the ride is to an SCD-related appointment so the agent can document it as critical. Members may choose to

have other people travel with them to their appointments, including children, attendants, other people under a member's care, or riders requested by a health care provider. When members schedule a ride, they should tell the agent if they are planning to bring someone with them to an appointment.

Topic #541

Codes

Physician-related procedure codes requiring PA (prior authorization) can be found in the interactive maximum allowable fee schedule.

Topic #22820

Hemgenix

Hemgenix requires clinical PA (prior authorization).

Hemgenix is covered and reimbursed under the pharmacy benefit. Providers should submit claims for Hemgenix to ForwardHealth using a noncompound drug claim. For specific questions about the billing or coverage of high cost, orphan, and accelerated approval drugs, providers may contact Provider Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

Additional Requirements for Hemgenix

Physician-administered Hemgenix is reimbursed separately from physician and clinical services associated with the administration of Hemgenix. The pharmacy provider is required to establish a delivery process with the prescriber to ensure that physician-administered Hemgenix is delivered directly to the prescriber or an agent of the prescriber. Pharmacy providers may only submit a claim to ForwardHealth for Hemgenix that has been administered to a member. If Hemgenix has been dispensed for a member but the dose is not administered to the member, the prescriber is responsible for notifying the dispensing pharmacy. If ForwardHealth has paid the dispensing pharmacy for any portion of the dispensing of Hemgenix that is not administered to the member, the dispensing pharmacy is responsible for reversing any claims submitted to ForwardHealth.

Clinical Criteria for Hemgenix

Clinical criteria that must be documented for approval of a PA request for Hemgenix are **all** of the following:

- Hemgenix must be prescribed by a hematologist at a dose of 2×10^{13} genome copies (gc) per kilogram of body weight.
- The member has been diagnosed with hemophilia B (congenital Factor IX deficiency).
- The member is 18 years of age or older.
- The member must currently be treated with Factor IX prophylaxis therapy.
- The member must have a current or historical life-threatening hemorrhage, or have repeated, serious spontaneous bleeding episodes.
- The prescriber must include documentation of Factor IX inhibitor titer testing. In case of a positive test result for human Factor IX inhibitors, perform a re-test within approximately 2 weeks. If both the initial test and re-test results are positive, PA for Hemgenix will not be approved.
- The prescriber must include documentation of liver health assessments including, ALT (alanine transaminase), AST (aspartate aminotransferase), ALP (alkaline phosphatase), total bilirubin, hepatic ultrasound, and hepatic elastography. If the member has radiological liver abnormalities and/or sustained liver enzyme elevations, documentation of a consultation with a hepatologist to assess eligibility for Hemgenix will be required.

Supporting clinical information and a copy of the member's current medical records must be included with all PA requests. The

supporting clinical information and the medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

PA requests for Hemgenix **will not** be approved if the member has any of the following conditions:

- Prior or current malignancy or myeloproliferative disorder or significant immunodeficiency disorder
- Prior allogenic or autologous HSC (hematopoietic stem cell) transplant

Submitting PA Requests for Hemgenix

PA requests for Hemgenix must be completed, signed, and dated by the prescriber. PA requests for Hemgenix must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (01/2024)) form. Clinical documentation supporting the use of Hemgenix must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) to ForwardHealth.

PA requests for Hemgenix may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Information is available about general ForwardHealth policy for drugs that require PA approval. This includes what may **not** be considered criteria to support the need for a drug.

Topic #23637

IV Ketamine Infusion Therapy

ForwardHealth covers IV ketamine infusion therapy with an approved PA (prior authorization) request for members diagnosed with MDD (major depressive disorder) with or without suicidality.

In accordance with federal law, ForwardHealth may establish coverage policy for off-label indications of covered outpatient drugs that are supported by clinical compendia. ForwardHealth will not accept PA requests for any other off-label indication for IV ketamine.

Clinical Criteria for IV Ketamine Infusion Therapy for Members Diagnosed With Major Depressive Disorder Without Suicidality

The clinical criteria for initial PA approval for IV ketamine infusion therapy for members diagnosed with MDD without suicidality **are all of the following:**

- The member has a confirmed diagnosis of MDD, as defined by the criteria in the current Diagnostic and Statistical Manual of Mental Disorders.
- The member's MDD is treatment resistant, meaning that the member's depression has not responded to two trials of

treatment with antidepressant drugs.
- The member is at least 18 years of age.
- The member does not have an active SUD (substance use disorder).
- The member experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction (during their current depressive episode) with at least two of the following:
  - A selective serotonin reuptake inhibitor
  - A serotonin-norepinephrine reuptake inhibitor
  - Bupropion
    Note: The two antidepressant drug types taken by the member must have different mechanisms of action and have been prescribed at the maximally tolerated labeled dose for at least four weeks.
- The requested treatment is used in combination with an oral antidepressant.

Clinical Criteria for IV Ketamine Infusion Therapy for Members Diagnosed With Major Depressive Disorder With Suicidality

The clinical criteria for initial PA approval for IV ketamine infusion therapy for members diagnosed with MDD with suicidality **are all of the following:**

- The member has a confirmed diagnosis of MDD, as defined by criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.
- The member is at least 18 years of age.
- The member does not have an active SUD.
- The member has active suicidal ideation that requires symptom control.
- The requested treatment is used in combination with an oral antidepressant.

PA Requests for IV Ketamine Infusion Therapy

Submit supporting clinical information and a copy of the member's current medical records with all PA requests for IV ketamine infusion therapy for members diagnosed with MDD with or without suicidality.

The supporting clinical information and medical records must include documentation that:

- The member's baseline is recorded using a validated depression screening tool (for example, PHQ-9 (Patient Health Questionnaire-9), QIDS (Quick Inventory of Depressive Symptomatology)).
- A standardized treatment plan is established and included in the member's medical record.
- The IV ketamine infusion therapy will be given under the direct supervision of a qualified health care professional, in accordance with a documented, standardized treatment and monitoring protocol.
- The IV ketamine infusion therapy is ordered by, or in coordination with, the member's managing mental health provider. (This could also be a primary care provider or other qualified health care professional.)

Initial and Amendment PA Requests for IV Ketamine Infusion Therapy

If the clinical criteria for IV ketamine infusion therapy for members diagnosed with MDD with or without suicidality are met:

- Initial PA requests may be approved for three months and a maximum of eight treatments.
- Amendment requests to extend treatment may be approved for six months and a maximum of 13 additional treatments. All amendment requests must be received before the expiration of the existing PA and provide required clinical documents.

IV ketamine infusion therapy is only authorized for the duration approved in the initial and renewal PA requests for members who are diagnosed with MDD with or without suicidality. ForwardHealth will not approve additional PA requests that would exceed the number of treatments allowed for in the initial and renewal PA requests. ForwardHealth will deny additional PA requests as noncovered services.

Renewal PA requests for IV ketamine infusion therapy for members diagnosed with MDD with or without suicidality must include copies of the member's current medical records demonstrating that:

- The prescriber attests that the member's depressive symptoms have improved from a documented baseline using a validated depression screening tool (for example, PHQ-9, QIDS).
- The member's IV ketamine infusion therapy use continues to be in combination with an oral antidepressant.

Submitting PA Requests for IV Ketamine Infusion Therapy

The prescriber must complete, sign, and date PA requests for IV ketamine infusion therapy for members diagnosed with MDD with or without suicidality. **The PA request must include clinical documentation (supporting clinical information and the member's medical records) to support the use of IV ketamine infusion therapy.**

The completed PA request should also include:

- CPT (Current Procedural Terminology) procedure code 96365 (Intravenous infusion, for therapy, prophylaxis, or diagnosis [specify substance or drug]; initial, up to 1 hour).
- The U4 modifier to indicate it is for IV ketamine infusion therapy approval.
    - No PA is required for the drug code.

When prescribers submit the PA requests, they must include the:

- PA/RF.
- PA/PA (Prior Authorization/Physician Attachment, F-11016 (07/2012)) form.
- IV Ketamine Infusion Therapy Attestation (IV Ketamine Infusion Therapy Attestation, F-03342 (01/2025)) form.

Prescribers must attest that the following statements are true:

- A treatment protocol is in place.
- A monitoring protocol is in place.
- ACLS (Advanced cardiovascular life support)-certified staff is on site at the time of the infusion.
- The prescriber is a registered provider with the DEA (Drug Enforcement Agency).

PA requests must be submitted on the Portal.

Prescribers submitting PA requests on the Portal must upload the IV Ketamine Infusion Therapy Attestation form as an attachment.

Topic #20717

Implanation of Artificial Heart

Implantation of an artificial heart is covered by ForwardHealth with an approved PA (prior authorization) request when the service is being used as a bridge to transplantation of a solid organ. Documentation of the following criteria must be submitted as part of the PA request:

- The member is at risk for imminent death from biventricular heart failure.
- The member has sufficient space in the chest cavity to accommodate the device.

Topic #23177

LITT

PA (Prior authorization) is required for coverage of LITT (Laser Interstitial Thermal Therapy), a minimally invasive surgical technique.

Prior Authorization Criteria

PA requests for LITT may be approved if at least one of the following criteria is met:

- Epilepsy
  - The member has disabling seizures despite the use of 2 or more antiepileptic drug regimens (i.e. medically-refractory epilepsy.
  - There is a well-defined epileptogenic focus in the member's temporal lobe or hypothalamus that can be accessed with LITT treatment.
    - May include, but may not be limited to, patients with lesional epilepsy due to focal structural pathology, such as a low grade glial tumor, cavernous malformation, malformation of cortical development (MCD) with medically refractory seizures.
- Malignant neoplasm of the brain
  - The member is experiencing recurrent malignant neoplasm, defined as cancerous tissue growth, that measures a maximum of 30 cubic centimeters (cc) in volume.
  - Medical professionals have determined the member is a poor surgical candidate for resection via craniotomy.
- Radiation necrosis
  - The member is experiencing radiation necrosis, defined as tissue death caused by radiation, that measures a maximum 30 cc in volume.
  - Medical professionals have determined the member is a poor surgical candidate for resection via craniotomy.

Prior Authorization Documentation

When requesting PA for LITT, providers are required to include all of the following:

- A completed PA/PA (Prior Authorization/Physician Attachment, F-11016 (07/2022))
- A completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026))
- A provider order for LITT
- Documentation showing evidence that a multidisciplinary team of physicians, including two or more specialists (such as a neurologist and neurosurgeon), have agreed to use LITT and have determined it to be the best treatment option over any others.

Topic #22579

Leqvio

Leqvio is a physician-administered drug that requires clinical PA (prior authorization).

All PA requests for Leqvio must be submitted with HCPCS (Healthcare Common Procedure Coding System) code J1306 (Injection, inclisiran, 1 mg).

PA requests for Leqvio must be completed, signed, and dated by the prescriber. PA requests for Leqvio must be submitted using Section V (Clinical Information for Physician-Administered Drugs With Specific PA Criteria Addressed in the ForwardHealth Online Handbook) on the PA/PAD (Prior Authorization/Physician-Administered Drug Attachment, F-11034 (07/2022)) form. Clinical documentation supporting the use of Leqvio must be submitted with the PA request.

Prescribers are required to submit the completed PA/PAD form and a completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) to ForwardHealth.

PA requests for Leqvio may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Conditions for Which PA Requests for Use of Leqvio Will Be Considered for Review

ForwardHealth will only consider PA requests for Leqvio to treat the following identified clinical conditions:

- Clinical ASCVD (atherosclerotic cardiovascular disease)
- HeFH (heterozygous familial hypercholesterolemia)

ForwardHealth will approve up to one ACL (adenosine triphosphate—citrate lyase) inhibitor **or** one PCSK9 (proprotein convertase subtilisin/kexin type 9) inhibitor at a time per member. ForwardHealth does not cover treatment with more than one ACL inhibitor and/or PCSK9 inhibitor.

Clinical Criteria for Leqvio for Members With Clinical Atherosclerotic Cardiovascular Disease

Clinical criteria that must be documented for approval of a PA request for Leqvio for members with clinical ASCVD are **all** of the following:

- The member has clinical ASCVD, as evidenced by **one** of the following:
  - The member has CAD (coronary artery disease), which is supported by a history of myocardial infarction (heart attack), coronary revascularization, or angina pectoris.
  - The member has a history of stroke.
  - The member has symptomatic peripheral arterial disease as evidenced by **one** of the following:
    - Intermittent claudication with an ABI (ankle-brachial index) of less than or equal to 0.9
    - Peripheral arterial revascularization procedure or amputation due to atherosclerotic disease
- The member has taken Praluent or Repatha concurrently with a maximized statin regimen for **at least three continuous months** with failure to reach an LDL (low-density lipoprotein) less than or equal to 70 mg/dL. The member must continue to take the maximally tolerated dose of a statin during treatment with Leqvio.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Leqvio. The supporting clinical information and medical records must document the following:

- Evidence that the member has clinical ASCVD
- A current lipid panel lab report
- Documentation of the member's current and previous lipid-lowering drug therapies, including the following for each trial:
  - Drug name(s) and dosage
  - Dates taken
  - Lipid panel report prior to and during drug therapy (including dates taken)
  - Reasons for discontinuation if drug therapy was discontinued

Initial and Renewal PA Requests for Leqvio for Members With Clinical Atherosclerotic Cardiovascular Disease

If the clinical criteria for Leqvio are met, initial PA requests may be approved for the initial and three-month doses.

Renewal PA requests for Leqvio may be approved for up to two doses per year. Renewal PA requests for members who have

clinical ASCVD must include supporting clinical information and copies of the member's current medical records demonstrating evidence of LDL reduction of at least 30 percent from pre-treatment baseline or a decrease to 100 mg/dL or less. Members also must continue to take the maximized statin treatment regimen during treatment with Leqvio.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current lipid panel report (within the past 30 days) must be included with the PA request.

Clinical Criteria for Leqvio for Members With Heterozygous Familial Hypercholesterolemia

Clinical criteria that must be documented for approval of Leqvio for members with HeFH are **all** of the following:

- The member has been diagnosed by a specialist in cardiology or lipid management.
- The member has HeFH, as evidenced by clinical documentation that supports a **definitive** diagnosis of HeFH using either WHO (World Health Organization) criteria (Dutch Lipid Clinic Network clinical criteria with a score greater than eight) or Simon Broome diagnostic criteria.
- The member has taken Praluent or Repatha concurrently with a maximized statin regimen for **at least three continuous months** with failure to reach an LDL less than or equal to 100 mg/dL. The member must continue to take the maximally tolerated dose of a statin during treatment with Leqvio.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Leqvio. The supporting clinical information and medical records must document the following:

- Evidence that the member has HeFH
- A current lipid panel lab report
- Documentation of the member's current and previous lipid -lowering drug therapies, including the following for each trial:
  - Drug name(s) and dosage
  - Dates taken
  - Lipid panel report prior to and during drug therapy (including dates taken)
  - Reasons for discontinuation if drug therapy was discontinued

Initial and Renewal PA Requests for Leqvio for Members With Heterozygous Familial Hypercholesterolemia

If the clinical criteria for Leqvio are met, initial PA requests may be approved for the initial and three-month doses.

Renewal PA requests for Leqvio may be approved for up to two doses per year. Renewal PA requests for members who have HeFH must include supporting clinical information and copies of the member's current medical records demonstrating evidence of LDL reduction of at least 30 percent from pre-treatment baseline or a decrease to 130 mg/dL or less. Members also must continue to take the maximized statin treatment regimen during treatment with Leqvio.

Topic #21199

Luxturna

Luxturna requires clinical PA (prior authorization).

Note: The Select High Cost, Orphan, and Accelerated Approval Drugs data table identifies select high cost, orphan, and accelerated approval drugs and interim billing and coverage information for these drugs. The table also identifies which drugs have specific PA or policy requirements. For specific questions about the billing or coverage of high cost, orphan, and accelerated approval drugs listed in the Select High Cost, Orphan, and Accelerated Approval Drugs data table, providers may contact Provider Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

Clinical Criteria for Luxturna

Clinical criteria that must be documented for approval of a PA request for Luxturna are **all** of the following:

- The member has a confirmed diagnosis of an inherited retinal dystrophy due to biallelic RPE65 mutations.
- The member has sufficient viable retinal cells (defined as an area of retinal thickness greater than 100 microns within the posterior pole) as measured by OCT (optical coherence tomography).
- The member has remaining light perception in the eye(s) that will receive treatment.
- Luxturna is prescribed and administered by an ophthalmologist or retinal surgeon with experience providing subretinal injections.

If clinical criteria for Luxturna are met, PA requests may be approved on a unilateral basis for up to four weeks (one lifetime dose per eye). For consideration of continued therapy on the second eye, **all** of the following must apply:

- All clinical criteria for initial PA request approval must be met.
- Administration is planned within a close interval to the treatment of the first eye, but at least six days apart.
- The PA request is not for a repeat treatment of a previously treated eye.

Submitting PA Requests for Luxturna

For PA requests for Luxturna, the prescriber is required to complete, sign, and date the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (01/2024)) form, using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the form. The prescriber is required to send the completed PA/DGA form to the pharmacy where the prescription will be filled. The pharmacy provider is required to complete a PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) and submit it, along with the PA/DGA form received from the prescriber, to ForwardHealth using the PA submission option most appropriate for the drug.

PA requests for Luxturna may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Topic #23657

Lyfgenia

Clinical PA (prior authorization) is required for Lyfgenia.

If a PA request for Lyfgenia is approved, Lyfgenia will be covered under the pharmacy benefit. To bill ForwardHealth for Lyfgenia, pharmacy providers should submit a pharmacy noncompound drug claim and must include the member's diagnosis code on the pharmacy claim submitted for Lyfgenia. The DOS (date of service) submitted on the pharmacy claim must be the date the member receives the infusion of Lyfgenia.

For specific questions about the billing or coverage of high cost, orphan, and accelerated approval drugs, providers may contact Provider Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

Lyfgenia Cell and Gene Therapy Access Model Requirements for Treatment Centers

Lyfgenia is a State-Selected Model Drug in the CMS' (Centers for Medicare & Medicaid Services') CGT (Cell and Gene Therapy) Access Model when used for the treatment of SCD (sickle cell disease).

The treatment center must agree to all of the following for members determined to be eligible in the CGT Access Model:

- Treatment center providers administering Lyfgenia for SCD must enroll and participate in the CMS-Designated Patient Registry through CIBMTR (Center for International Blood and Marrow Transplant Research).
- Treatment center providers must be enrolled in CIBMTR before administering Lyfgenia to Wisconsin Medicaid members.
- Treatment center providers must also obtain member consent to participate in the CIBMTR Research Database Protocol under which this study will be governed and are responsible for submitting data to CIBMTR, per the CGT Access Model study requirements.
- Treatment center providers administering Lyfgenia for SCD must ensure Lyfgenia is not purchased through the 340B Program when administered to eligible CGT Access Model members.

For assistance with enrollment in the CMS-Designated Patient Registry for the CMS CGT Access Model, providers may email CIBMTR at CGTModel@mcw.edu.

Requirements for Lyfgenia

Lyfgenia will be reimbursed separately from physician and clinical services associated with the administration of Lyfgenia. The pharmacy provider is required to establish a delivery process with the prescriber to ensure that the physician-administered Lyfgenia is delivered directly to the administering treatment center.

Pharmacy providers may only submit a claim to ForwardHealth for Lyfgenia that has been administered to a member. If Lyfgenia has been dispensed for a member but the dose is not administered to the member, the prescriber is responsible for notifying the dispensing pharmacy. If ForwardHealth has paid the dispensing pharmacy for any portion of the dispensing of Lyfgenia that is not administered to the member, the dispensing pharmacy is responsible for reversing any claims submitted to ForwardHealth.

Lyfgenia must be prescribed at a minimum recommended dose of 3×10^6 CD34+ cells/kg of body weight.

The member must have full myeloablative conditioning administered before infusion of Lyfgenia. Full myeloablative conditioning must be administered a minimum of 48 hours before infusion of Lyfgenia.

Standard procedures for patient management after HSC (hematopoietic stem cell) transplantation should be followed after Lyfgenia infusion.

The prescriber must manage other concomitant medications (as applicable) consistent with FDA (Food and Drug Administration) product labeling.

The member must not take disease-modifying therapies for SCD (for example, crizanlizumab, L-glutamine, voxelotor) for at least two months prior to mobilization.

The member must not take iron chelation therapy at least seven days prior to mobilization and conditioning. If the member takes iron chelation after apheresis, the member must discontinue iron chelation at least seven days prior to myeloablative conditioning. Myelosuppressive iron chelators are not recommended for six months after Lyfgenia infusion.

The member must not take erythropoietin for at least two months prior to mobilization.

The member must not take hydroxyurea at least two months prior to mobilization and two days prior to conditioning and will not resume until all cycles of apheresis are completed.

The member must not take prophylactic HIV anti-retroviral medications for at least one month prior to mobilization and until all cycles of apheresis are completed. Adjust time appropriately for long-acting anti-retroviral medications.

G-CSF (Granulocyte-Colony Stimulating Factor) must not be used prior to or with mobilization and conditioning. G-CSF is not

recommended for at least 21 days after Lyfgenia infusion.

PA Information for Lyfgenia

Clinical Criteria for Lyfgenia

Clinical criteria that must be documented for approval of a PA request for Lyfgenia for SCD are **all** of the following:

- Lyfgenia must be prescribed and administered by a physician and at a treatment center with expertise in treating SCD with Lyfgenia.
- The prescribing provider attests that at least one of the following is true:
  - The member has experienced an unsatisfactory therapeutic response with hydroxyurea.
  - The member has experienced a clinically significant adverse drug reaction with hydroxyurea.
  - There is a clinically significant drug interaction between another drug(s) the member is taking and hydroxyurea.
  - The member has a medical condition(s) that prevents the use of hydroxyurea.
- The prescribing provider attests that the member is currently receiving chronic transfusion therapy for recurrent VOEs (vaso-occlusive events) or the member has experienced four or more VOEs in the previous 24 months.
- The member's age at the time of the planned infusion must be consistent with FDA-approved product labeling for Lyfgenia.
- The prescriber will provide documentation of completed negative screening for active infectious diseases including HBV (hepatitis B virus), HCV (hepatitis C virus), HIV 1 and 2 (HIV-1/HIV-2) and HTLV (Human T-lymphotropic virus) 1 and 2 (HTLV-1/HTLV-2), in accordance with clinical guidelines before collection of cells for manufacturing.
- The prescriber has attested that the member is clinically stable and fit for transplantation.

Conditions Not Approved for PA Requests for Lyfgenia

PA requests for Lyfgenia **will not** be approved if the member has any of the following conditions:

- Advanced liver disease (for example, alanine transaminases greater than three times the upper limit of normal, direct bilirubin value greater than 3 times the upper limit of normal, baseline prothrombin time [INR (international normalized ratios)] greater than 1.5 times the upper limit of normal, cirrhosis, bridging fibrosis, or active hepatitis)
- A history of untreated Moyamoya disease or the presence of Moyamoya disease that, in the opinion of the prescriber, puts the member at risk of bleeding
- Current malignancy, myeloproliferative disorder, or significant immunodeficiency disorder, unless the prescribing provider attests that the member's condition would not deem the member ineligible for treatment
- Prior allogenic or autologous HSC transplant

Submitting PA Requests for Lyfgenia

PA requests for Lyfgenia must be completed, signed, and dated by the prescriber. PA requests for Lyfgenia must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (01/2024)) form. Clinical documentation supporting the use of Lyfgenia must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed and a completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) to ForwardHealth.

PA requests for Lyfgenia may be submitted Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

PA requests for Lyfgenia will be approved for 365 days.

Information is available about general ForwardHealth policy for drugs that require PA approval. This includes what may **not** be considered criteria to support the need for a drug.

Topic #4516

Non-Implant Bone-Anchored Hearing Devices

Non-implant bone-anchored hearing devices (HCPCS (Healthcare Common Procedure Coding System) procedure code L8692) require PA (prior authorization). All of the following criteria must be met before PA requests for non-implant bone-anchored hearing devices can be approved:

- The member has a conductive and/or mixed hearing loss (unilateral or bilateral) with pure-tone average bone-conduction thresholds (measured at 0.5, 1, 2, and 3 kHz) less than or equal to 65 dB HL. The threshold range is intended to accommodate different degrees of hearing loss and corresponding output power of the bone-anchored hearing device.
- The member demonstrates an air-bone gap of at least 30 dB.
- The member demonstrates a word recognition score greater than 60% via conventional air-conduction speech audiometry using single-syllable words.
- The member has one or more of the following conditions:
  - Severe chronic external otitis or otitis media
  - Chronic draining ear through a tympanic membrane perforation
  - Malformation of the external auditory canal or middle ear
  - Stenosis of the external auditory canal
  - Ossicular discontinuity or erosion that cannot be repaired
  - Chronic dermatologic conditions such as psoriasis of the ear canal
  - Tumors of the external canal and/or tympanic cavity
  - Other conditions that prevent restoration of hearing using a conventional air-conduction hearing aid

When requesting PA for non-implant bone-anchored hearing devices, providers are required to submit a completed PA/HIAS2 (Prior Authorization Request for Hearing Instrument and Audiological Services, F-11021 (07/2012)) documenting the medical necessity of the non-implant bone-anchored hearing device.

Topic #23617

Omvoh IV for Crohn's Disease and Ulcerative Colitis

Omvoh IV is a physician-administered drug that requires clinical PA (prior authorization).

All PA requests for Omvoh IV must be submitted with HCPCS (Healthcare Common Procedure Coding System) code J2267 (Injection, mirikizumab-mrkz, 1 mg).

Note: Modifier JA (Administered intravenously) may be needed for billing.

PA requests for Omvoh IV must be completed, signed, and dated by the prescriber. PA requests for Omvoh IV must be submitted using Section V (Clinical Information for Physician-Administered Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) on the PA/PAD (Prior Authorization/Physician-Administered Drug Attachment, F-11034 (07/2022)) form. Clinical documentation supporting the use of Omvoh IV must be submitted with the PA request.

Prescribers are required to submit the complete PA/PAD form and a completed PA/RF (Prior Authorization Request Form, F-

11018 (04/2026)) to ForwardHealth. PA requests for Omvoh IV may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Information is available about general ForwardHealth policy for drugs that require PA approval. This includes what may **not** be considered criteria to support the need for a drug.

Conditions for Which PA Requests for Use of Omvoh IV Will Be Considered for Review

ForwardHealth will only consider PA requests for Omvoh IV to treat the following conditions:

- Crohn's disease
- Ulcerative colitis

Clinical Criteria for Omvoh IV for Crohn's Disease

Clinical criteria that must be documented for approval of a PA request for Omvoh IV for members with Crohn's disease are **all** of the following:

- The member has Crohn's disease.
- The member has been diagnosed by a gastroenterologist.
- **Two** of the following are true:
  - The member has taken Cimzia for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Hadlima or Humira for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Selarsdi subQ or Steqeyma subQ for at least three consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why Omvoh IV is being requested.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Omvoh IV for members with Crohn's disease. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan
- The member's current weight

If the clinical criteria for Omvoh IV for members with Crohn's disease are met, PA requests will only be approved for the three intravenous induction doses.

Note: A separate PA request must be obtained for maintenance treatment with Omvoh subQ. PA for Omvoh subQ must be obtained through the pharmacy PA process.

Clinical Criteria for Omvoh IV for Ulcerative Colitis

Clinical criteria that must be documented for approval of a PA request for Omvoh IV for members with ulcerative colitis are **all** of the following:

- The member has ulcerative colitis.
- The member has been diagnosed by a gastroenterologist.

- **Two** of the following are true:
  - The member has taken Hadlima or Humira for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Selarsdi subQ or Steqeyma subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Simponi subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Xeljanz or Xeljanz XR for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why Omvoh IV is being requested.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Omvoh IV. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If the clinical criteria for Omvoh IV are met, PA requests will only be approved for the three IV induction doses.

Note: A separate PA request must be obtained for maintenance treatment with Omvoh subQ. PA for Omvoh subQ must be obtained through the pharmacy PA process.

Topic #19817

Personal Continuous Glucose Monitoring Devices and Supplies

ForwardHealth covers personal continuous glucose monitors and supplies in accordance with guidance from the American Diabetes Association and American Association of Clinical Endocrinology for diabetic members who are on insulin, need to check their blood sugar frequently, or are at risk for hypoglycemia. Adults and children, including infants and toddlers, may use a personal continuous glucose monitoring device and supplies to estimate blood glucose levels automatically, which will allow levels to be reviewed and tracked closely.

Coverage Criteria

Personal continuous glucose monitors and supplies are covered for members who meet all of these criteria:

- The member has a diagnosis of any type of diabetes, excluding pre-diabetes.
- The member or the member's caregiver has the cognitive ability to be educated about the device, the willingness to use the device, and the physical capability to use the device.
- The member has a written prescription dated within the last 12 months from a qualified health care professional on the member's medical team, including the name of the continuous glucose monitor prescribed.
- The prescribed continuous glucose monitor is appropriate for the member's age.

Continuous glucose monitors and supplies are covered under ForwardHealth's DME (durable medical equipment) benefit.

Required Documentation

This documentation for fee-for-service claims must be kept in the member's medical record, dated within the last 12 months and

must be produced upon the request of Wisconsin DHS (Department of Health Services):

- Documentation of the member's diabetes diagnosis
- A written prescription from a licensed, qualified health care professional on the member's medical team
- A qualified health care professional-ordered diabetic treatment plan
- The name of the prescribed glucose monitoring device
- Documentation that the member or the member's caregiver has the cognitive ability to be educated about the device, the willingness to use the device, and the physical capability to use the device

Prior Authorization

PA (Prior authorization) is required:

- For out-of-state, non-border-status providers.
- For prescription of a backup device.
- If a new device is required within three years of having had one dispensed. (Note: Continuous glucose monitors have an expected life of three years, and members can receive one every three years without PA.)

When a PA is needed, this information must be submitted:

- A completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026))
- A completed PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (02/2024))
- Documentation of the member's diabetes diagnosis
- A written prescription dated within the last 12 months, including the name of the continuous glucose monitor prescribed, from a licensed qualified health care professional on the member's medical team
- A qualified health care professional-ordered diabetic treatment plan
- The name of the prescribed glucose monitoring device
- Documentation that the member or the member's caregiver has the cognitive ability to be educated about the device, the willingness to use the device, and the physical capability to use the device

HMOs have the option to require PA for these devices.

Topic #15777

Prior Authorization for Botulinum Toxins to Treat Other Diagnoses

The following must be submitted to request PA (prior authorization) for a botulinum toxin for a diagnosis not on the Diagnosis Code-Restricted Physician-Administered Drugs data table:

- A completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026))
- A completed PA/PAD (Prior Authorization/Physician-Administered Drug Attachment, F-11034 (07/2022))

In addition to the PA request forms, providers are required to submit peer-reviewed medical literature to support the proven efficacy of the botulinum toxin for the specific condition that is to be treated.

Providers may submit PA requests and necessary documentation on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Topic #15097

Prior Authorization for OnabotulinumtoxinA (Botox)

Botox is a neurotoxin used to treat a number of diagnoses including (but not limited to) cervical dystonia, limb spasticity, strabismus, chronic migraines, and urinary incontinence.

Botox is covered for members enrolled in BadgerCare Plus and Medicaid. It is not covered for SeniorCare members.

For members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, claims for Botox should be submitted to BadgerCare Plus and Medicaid fee-for-service for reimbursement.

Botox for Use to Treat Chronic Migraines

A dosing range of no greater than 200 units per treatment is considered acceptable for the use of Botox to treat chronic migraines.

Providers Who May Administer Botox To Treat Chronic Migraines

The following licensed and Medicaid-enrolled providers familiar with and experienced in the use of Botox may administer this agent to treat chronic migraines:

- Nurse practitioners
- Physician assistants
- Physicians

When using Botox to treat **chronic** migraines, the rendering provider is required to follow the procedures for diagnosis-restricted physician-administered drugs.

Claims for Botox to treat chronic migraines are only reimbursable without PA (prior authorization) when submitted with one of the approved ICD (International Classification of Diseases) diagnosis codes.

Clinical Criteria for Coverage of Botox to Treat Chronic Migraines

Clinical criteria for coverage of Botox for the treatment of chronic migraines are **all** of the following:

- The member is 18 years of age or older.
- The dosing range is no greater than 200 units per treatment.
- The service is ordered by the provider who has evaluated and diagnosed the member as experiencing chronic migraines using the revised International Headache Society criteria for chronic migraines.
- The member has experienced headaches (tension-type and/or migraine) for **three or more** months that have lasted **four or more** hours per day on **15 or more** days per month, with **eight or more** headache days per month being migraines/probable migraines (and that are not due to medication overuse or attributed to another causative disorder).
- The member scored a grade indicating moderate to severe disability on the MIDAS (Migraine Disability Assessment) test, or on a similar validated tool. The MIDAS test was developed by the American Headache Society for Headache Education.
- The rendering provider has discussed alternative non-pharmacological treatment options with the member, such as behavioral therapies, physical therapies, and lifestyle modifications.
- **One** of the following is true:
  - The member has tried migraine prophylaxis medications from **three or more** of the drug categories listed below and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
    - Antidepressants
    - Anticonvulsants
    - Beta blockers

    - Calcium channel blockers
    - Other drugs
- The member has a medical condition that prevents them from trying migraine prophylaxis medications from **three or more** of the drug categories listed above, or there is a clinically significant drug interaction with a medication the member is currently taking that prevents them from trying migraine prophylaxis medications from **three or more** of the drug categories listed above.

Note: In order for the member to qualify for the treatment, their medical record must support the clinical criteria outlined, and the medical records must be made available upon audit request.

If one of the ForwardHealth-approved chronic migraine diagnoses is appropriate for the member, but not all of the above clinical criteria are met, the provider may submit a PA request on the PA/PAD (Prior Authorization/Physician-Administered Drug Attachment, F-11034 (07/2022)) form along with clinical documentation explaining the reason for the PA request. Depending on the specific clinical criteria that have not been met, the prescriber is required to submit appropriate clinical documentation, such as the following:

- Peer-reviewed medical literature to support the proven efficacy and safety of the requested use
- Documentation of the clinical rationale to support the medical necessity
- Documentation of previous treatments and detailed reasons why other covered drug treatments were discontinued or not utilized
- Medical records

PA requests for Botox may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Treatment Frequency

If a member meets the clinical criteria for coverage of Botox for the treatment of chronic migraines, ForwardHealth will cover no more than two treatments in six months.

To continue treatment, a member must experience clinically significant and documented improvement in the frequency or duration of chronic migraines using at least **one** of the following indicators:

- Reduction in acute services, emergency services, or need for rescue treatment for acute chronic migraines
- At least a 40% reduction in the frequency, severity, or length of chronic migraines
- Improved assessment score on the MIDAS test or on a similar validated tool
- Reduced use of analgesics

Overall frequency of treatment should not exceed more than one treatment every three months.

Botox for Use to Treat Other Diagnoses

For uses other than the treatment of chronic migraines, Botox is a diagnosis-restricted drug.

Topic #10737

Screening Computed Tomographic Colonography

All PA (prior authorization) requests for screening CT (computed tomographic) colonography will be adjudicated and processed by eviCore healthcare, a private radiology benefits manager authorized to administer PA for advanced imaging services on behalf of ForwardHealth. Providers are required to work directly with eviCore healthcare to submit PA requests for screening CT colonography.

Topic #21201

Select High Cost, Orphan, or Accelerated Approval Drugs

Prior Authorization Requirements for Select High Cost, Orphan, or Accelerated Approval Drugs

Select high cost, orphan, or accelerated approval drugs may require PA (prior authorization), but in some cases, ForwardHealth will not establish drug-specific clinical criteria. For PA requests for select high cost, orphan, or accelerated approval drugs without drug-specific clinical criteria, the prescriber is required to complete, sign, and date the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (01/2024)) form, using Section VII (Clinical Information for Other Drug Requests) of the form. The prescriber is required to send the completed PA/DGA form to the pharmacy where the prescription will be filled. The pharmacy provider is required to complete a PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) and submit it, along with the PA/DGA form received from the prescriber, to ForwardHealth using the PA submission option most appropriate for the drug.

If a high cost, orphan, or accelerated approval drug requires PA, but drug-specific clinical criteria are not established, PA requests for these drugs require the submission of medical records (for example, chart notes, laboratory values) to support that the drug being prescribed is for an FDA (Food and Drug Administration)-approved indication and is medically necessary as defined by Wis. Admin. Code § DHS 101.03(96m). The drug must be prescribed in a dose and manner consistent with FDA-approved product labeling. These PA requests will be reviewed on a case-by-case basis for medical necessity.

PA requests for these drugs may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Note: For specific questions about the billing or coverage of high cost, orphan, and accelerated approval drugs listed in the Select High Cost, Orphan, and Accelerated Approval Drugs data table, providers may contact Provider Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

Claim Requirements for Physician-Administered-Drugs

Physician-administered drugs will be reimbursed separately from physician and clinical services associated with the administration of select, high cost, and accelerated approval drugs.

The pharmacy provider is required to establish a delivery process with the prescriber to ensure that physician-administered drugs are delivered directly to the prescriber, an agent of the prescriber, or a health care provider designated to administer the drug to the member. Pharmacy providers may only submit a claim to ForwardHealth for the physician-administered drug that has been administered to a member.

If a physician-administered drug has been dispensed for a member but the dose is not administered to the member, the prescriber or health care provider designated to administer the drug to the member is responsible for notifying the dispensing pharmacy. If ForwardHealth has paid the dispensing pharmacy for any portion of the dispensing of the physician-administered drug that is not administered to the member, the dispensing pharmacy is responsible for reversing any claims submitted to ForwardHealth.

Clinical Criteria for Select High Cost, Orphan, or Accelerated Approval Drugs

The Select High Cost, Orphan, and Accelerated Approval Drugs data table identifies high cost, orphan, and accelerated approval drugs that require PA to support that use will be for an FDA-approved indication; PA requests for these drugs will be reviewed on a case-by-case basis for medical necessity.

As new high cost, orphan, and accelerated approval drugs enter the market, ForwardHealth will use the Select High Cost, Orphan, and Accelerated Approval Drugs data table to identify whether or not these drugs require PA. For drugs that require PA, the table will indicate whether or not the drugs have drug-specific PA clinical criteria.

Topic #22818

Skyrizi IV for Crohn's Disease and Ulcerative Colitis

Skyrizi IV is a physician-administered drug that requires clinical PA (prior authorization).

All PA requests for Skyrizi IV must be submitted with HCPCS (Healthcare Common Procedure Coding System) procedure code J2327 (Injection, risankizumab-rzaa, intravenous, 1 mg).

PA requests for Skyrizi IV must be completed, signed, and dated by the prescriber. PA requests for Skyrizi IV must be submitted using Section V (Clinical Information for Physician-Administered Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) on the PA/PAD (Prior Authorization/Physician-Administered Drug Attachment, F-11034 (07/2022)) form. Clinical documentation supporting the use of Skyrizi IV must be submitted with the PA request.

Prescribers are required to submit the completed PA/PAD form and a completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) to ForwardHealth. PA requests for Skyrizi IV may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Conditions for Which PA Requests for Use of Skyrizi IV Will Be Considered for Review

ForwardHealth will only consider PA requests for Skyrizi IV to treat the following clinical conditions:

- Crohn's disease
- Ulcerative colitis

Clinical Criteria for Skyrizi IV for Crohn's Disease

Clinical criteria that must be documented for approval of a PA request for Skyrizi IV for members with Crohn's disease are **all** of the following:

- The member has Crohn's disease.
- The member has been diagnosed by a gastroenterologist.
- **Two** of the following are true:
  - The member has taken Cimzia for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Hadlima or Humira for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Selarsdi subQ or Steqeyma subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why Skyrizi IV is being requested.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Skyrizi IV for members with Crohn's disease. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If the clinical criteria for Skyrizi IV for members with Crohn's disease are met, PA requests will only be approved for the three intravenous induction doses.

Note: A separate PA request must be obtained for maintenance treatment with Skyrizi subQ. PA for Skyrizi subQ must be obtained through the pharmacy PA process.

Clinical Criteria for Skyrizi IV for Ulcerative Colitis

Clinical criteria that must be documented for approval of a PA request for Skyrizi IV for members with ulcerative colitis are **all** of the following:

- The member has ulcerative colitis.
- The member has been diagnosed by a gastroenterologist.
- **Two** of the following are true:
  - The member has taken Hadlima or Humira for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Selarsdi subQ or Steqeyma subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Simponi subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significatnt adverse drug reaction.
  - The member has taken Xeljanz or Xeljanz XR for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why Skyrizi IV is being requested.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Skyrizi IV for members with ulcerative colitis. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If the clinical criteria for Skyrizi IV for members with ulcerative colitis are met, PA requests will only be approved for the IV induction dose.

Note: A separate PA request must be obtained for maintenance treatment with Skyrizi subQ. PA requests for Skyrizi subQ must be obtained through the pharmacy PA process.

Topic #23358

Skysona

Skysona requires clinical PA (prior authorization).

If a PA request for Skysona is approved, Skysona will be covered under the pharmacy benefit. Skysona is only indicated for use in boys. To bill ForwardHealth for Skysona, pharmacy providers should submit a pharmacy noncompound drug claim.

For questions about the billing or coverage of high cost, orphan, and accelerated approval drugs, providers may contact Provider

Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

Additional Requirements for Skysona

Skysona will be reimbursed separately from physician and clinical services associated with the administration of Skysona. The pharmacy provider is required to establish a delivery process with the prescriber to ensure that the physician-administered Skysona is delivered directly to the prescriber or an agent of the prescriber.

Pharmacy providers may only submit a claim to ForwardHealth for the Skysona that has been administered to a member. If Skysona has been dispensed for a member but the dose is not administered to the member, the prescriber is responsible for notifying the dispensing pharmacy. If ForwardHealth has paid the dispensing pharmacy for any portion of the dispensing of Skysona that is not administered to the member, the dispensing pharmacy is responsible for reversing any claims submitted to ForwardHealth.

Clinical Criteria for Skysona

Clinical criteria that must be documented for approval of a PA request for Skysona are **all** of the following:

- Skysona must be prescribed by a physician with expertise in treating early, active CALD (cerebral adrenoleukodystrophy) at a minimum recommended dose of 5.0 X 10^6 CD34+ cells/kg.
- The member has early, active CALD not due to head trauma. Early, active CALD is defined as asymptomatic or mildly symptomatic (neurologic function score less than or equal to 1) in boys who have gadolinium enhancement on brain MRI and Loes scores of 0.5–9.
- The member's age is consistent with the FDA (Food and Drug Administration)-approved product labeling for Skysona.
- The member will undergo HSC (hematopoietic stem cell) mobilization, apheresis, and myeloablative conditioning. The prescriber must confirm the member has been evaluated for renal and hepatic impairment and HSC transplantation is appropriate for the member.
- The member must have full myeloablative and lymphodepleting conditioning administered before infusion of Skysona. Allow a minimum of 48 hours of washout before Skysona infusion.
- The prescriber will complete screening for infectious diseases including HBV (hepatitis B virus), HCV (hepatitis C virus), HIV 1 and 2 (HIV-1/HIV-2) and HTLV (Human T-lymphotropic virus) 1 and 2 (HTLV-1/HTLV-2) in accordance with clinical guidelines before collection of cells for manufacturing.
- Standard procedures for patient management after HSC transplantation should be followed after Skysona infusion.
- The prescriber must manage other concomitant medications (as applicable) consistent with FDA product labeling.
- The member must not take anti-retroviral medications for at least one month prior to stem cell mobilization and for the expected duration for elimination of the medications and until all cycles of apheresis are complete.
- If a member requires anti-retroviral medications for HIV prophylaxis, mobilization and apheresis should be delayed until HIV infection is adequately ruled out.

Submitting PA Requests for Skysona

PA requests for Skysona must be completed, signed, and dated by the prescriber. PA requests for Skysona must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (01/2024)) form. Clinical documentation supporting the use of Skysona must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) to ForwardHealth.

PA requests for Skysona may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Information is available about general ForwardHealth policy for drugs that require PA approval, including what may **not** be considered criteria to support the need for a drug.

Topic #22097

Spinal Muscular Atrophy Drugs

Clinical PA (prior authorization) is required for all SMA (spinal muscular atrophy) drugs.

ForwardHealth does not cover treatment using more than one SMA drug at a time. If a member is transitioning treatment from Spinraza to Evrysdi, a waiting period of 90 days from the last injection of Spinraza is required before starting Evrysdi. The member's current approved PA request for Spinraza will be end-dated upon approval of Evrysdi. If a member is transitioning treatment from Evrysdi to Spinraza, the member's current approved PA request for Evrysdi will be end-dated upon approval of Spinraza. If a member previously received treatment with Zolgensma or Itvisma, a PA request for another SMA drug treatment will be denied.

Claims Submission for Spinal Muscular Atrophy Drugs

SMA drugs, including Evrysdi, will be covered and reimbursed under the pharmacy benefit. Providers should submit claims for SMA drugs to ForwardHealth using a noncompound drug claim. For specific questions about the billing or coverage of high cost, orphan, and accelerated approval drugs Spinraza, Zolgensma, or Itvisma, providers may contact Provider Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

Additional Requirements for Physician-Administered Spinal Muscular Atrophy Drugs

Physician-administered SMA drugs (for example, Spinraza, Zolgensma, and Itvisma) are reimbursed separately from physician and clinical services associated with the administration of SMA drugs. The pharmacy provider is required to establish a delivery process with the prescriber to ensure that the physician-administered SMA drugs are delivered directly to the prescriber or an agent of the prescriber.

Pharmacy providers may only submit a claim to ForwardHealth for the SMA drugs that have been administered to a member. If an SMA drug has been dispensed for a member but the dose is not administered to the member, the prescriber is responsible for notifying the dispensing pharmacy. If ForwardHealth has paid the dispensing pharmacy for any portion of the dispensing of an SMA drug that is not administered to the member, the dispensing pharmacy is responsible for reversing any claims submitted to ForwardHealth.

Evrysdi

Clinical Criteria for Evrysdi

The following clinical criteria must be met and documented for approval of a PA request for Evrysdi:

- Evrysdi is prescribed by a neurologist, pulmonologist, or other physician with expertise in treating SMA and in a manner consistent with the FDA (Food and Drug Administration)-approved product labeling.
- The member receives medication counseling prior to initiating Evrysdi treatment, and the provider must comply with administration requirements per FDA labeling. (Medication must be dosed after a meal, patients are instructed to drink water after the dose is administered, and medication must be given within five minutes after it has been drawn up into the

oral syringe.)
- The member has SMA type 1, 2, or 3, which has been confirmed by genetic testing (5q SMN1 (survival motor neuron 1): homozygous mutation, homozygous gene deletion, or compound heterozygote).
- The member has **at least two** copies of the SMN2 (survival motor neuron 2) gene.
- The prescriber submits exam values from **at least one** of the following exams (based on member age and motor ability) to establish a baseline motor ability:
  - HINE (Hammersmith Infant Neurological Examination) (infant to early childhood)
  - HFMSE (Hammersmith Functional Motor Scale Expanded)
  - RULM (Revised Upper Limb Module) test (non-ambulatory members)
  - CHOP INTEND (Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders)
  - 6MWT (six-minute walk test) (ambulatory members)
  - MFM32 (Motor Function Measure 32)
- The prescriber indicates the member's pulmonary status, including any requirement for ventilator support.

ForwardHealth will consider coverage for Evrysdi on a case-by-case basis if any of the following circumstances are present for the member:

- Complete paralysis of the limbs
- Ventilator dependent for 16 or more hours per day (including non-invasive respiratory support)

A copy of the member's medical records must be submitted and should sufficiently document:

- The information listed in the clinical criteria for PA approval.
- Details regarding previous medication use.
- The member's current treatment plan.

ForwardHealth will deny PA requests for Evrysdi if any of the following circumstances are present:

- The member is currently involved in a clinical trial for an SMA drug.
- The member has received treatment with Zolgensma.
- The member has received treatment with Itvisma.
- The member is **currently** receiving treatment with Spinraza.
- The member is diagnosed with a non-SMN1 variant of SMA.

Initial PA requests for Evrysdi to treat SMA may be approved for up to 183 days.

Renewal PA Requests

In addition to meeting the clinical criteria for initial PA request approval, renewal PA requests for Evrysdi require the submission of medical records (for example, chart notes, assessment of neurological and motor function) with the most recent results (less than two months prior to the submission of the renewal PA request) documenting a positive clinical response to Evrysdi therapy **from pretreatment baseline status** as demonstrated by **one** or more of the following exams:

- HINE that demonstrates the following:
  - Improvement or maintenance of previous improvement of at least a two-point (or maximal score) increase in the ability to kick **or** improvement or maintenance of previous improvement of at least a one-point increase in any other HINE milestone (for example, head control, rolling, sitting, crawling), excluding voluntary grasp
  - Net positive improvement in condition, defined as building on previous improvement from the pretreatment baseline in a majority of the HINE motor milestones **or** achievement or maintenance of any new motor milestone(s) from the pretreatment baseline when the member would otherwise not be expected to do so (for example, sit unassisted, stand, walk)
- HFMSE that demonstrates **one** of the following:
  - Improvement or maintenance of previous improvement of at least a three-point increase in score from pretreatment

baseline
    - Achievement and maintenance of any new motor milestone(s) from pretreatment baseline when the member would otherwise not be expected to do so
- RULM test that demonstrates **one** of the following:
    - Improvement or maintenance of previous improvement of at least a two-point increase in score from pretreatment baseline
    - Achievement and maintenance of any new motor milestone(s) from pretreatment baseline when the member would otherwise not be expected to do so
- CHOP INTEND that demonstrates **one** of the following:
    - Improvement or maintenance of previous improvement of at least a four-point increase in score from pretreatment baseline
    - Achievement and maintenance of any new motor milestone(s) from pretreatment baseline when the member would otherwise not be expected to do so
- MFM32 that demonstrates **one** of the following:
    - Improvement or maintenance of previous improvement of at least a two-point increase in score from pretreatment baseline
    - Achievement and maintenance of any new motor milestone(s) from pretreatment baseline when the member would otherwise not be expected to do so

Renewal PA requests for Evrysdi used to treat SMA may be approved for up to 365 days.

Submitting PA Requests for Evrysdi

PA requests for Evrysdi must be submitted using the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (01/2024)) form.

PA requests for Evrysdi must be completed, signed, and dated by the prescriber. PA requests for Evrysdi should be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) to ForwardHealth.

PA requests for Evrysdi may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Itvisma

Clinical Criteria for Itvisma

The following clinical criteria must be met and documented for approval of a PA request for Itvisma:

- Itvisma is prescribed by a neurologist, pulmonologist, or other physician with expertise in treating SMA and in a manner consistent with the FDA-approved product labeling.
- The member is 2 years of age or older.
- The member has SMA that has been confirmed by genetic testing (SMN1 mutation).
- The member does not have advanced SMA including, but not limited to, any of the following:
    - Complete paralysis of the limbs
    - Ventilator dependent for 16 or more hours per day (including non-invasive respiratory support)

- The prescriber submits the most recent pre-treatment anti-AAV9 (adeno-associated virus serotype 9) antibody testing, demonstrating a titer ratio of less than 50 to 1.

A copy of the member's medical records must be submitted and should sufficiently document:

- The information listed in the clinical criteria for PA approval.
- Details regarding previous medication use.
- The member's current treatment plan.

Note: ForwardHealth covers one treatment per lifetime with Itvisma for members 2 years of age or older.

ForwardHealth will deny PA requests for Itvisma if any of the following circumstances are present:

- The member is currently involved in a clinical trial for an SMA drug.
- The member is diagnosed with a non-SMN1 variant of SMA.
- The member is under 2 years of age.

Submitting PA Requests for Itvisma

PA requests for Itvisma must be submitted using the PA/DGA form.

PA requests for Itvisma must be completed, signed, and dated by the prescriber. PA requests for Itvisma should be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for Itvisma may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Spinraza

Clinical Criteria for Spinraza

The following clinical criteria must be met and documented for approval of a PA request for Spinraza:

- Spinraza is prescribed by a neurologist, pulmonologist, or other physician with expertise in treating SMA and in a manner consistent with the FDA-approved product labeling.
- The member has SMA type 1, 2, or 3, which has been confirmed by genetic testing (5q SMN1: homozygous mutation, homozygous gene deletion, or compound heterozygote).
- The member has **at least two** copies of the SMN2 gene.
- The prescriber submits exam values from **at least one** of the following exams (based on member age and motor ability) to establish a baseline motor ability:
  - HINE (infant to early childhood)
  - HFMSE
  - RULM test (non-ambulatory members)
  - CHOP INTEND
  - 6MWT (ambulatory members)
- The prescriber indicates the member's pulmonary status, including any requirement for ventilator support.

ForwardHealth will consider coverage for Spinraza on a case-by-case basis if any of the following circumstances are present for the member:

- Complete paralysis of the limbs
- Ventilator dependent for 16 or more hours per day (including non-invasive respiratory support)
- Pre-symptomatic infants who have not yet developed symptoms but have undergone genetic studies indicating a high likelihood of developing SMA type 1, 2, or 3 (that is, less than three copies of the SMN2 gene)

A copy of the member's medical records must be submitted and should sufficiently document:

- The information listed in the clinical criteria for PA approval.
- Details regarding previous medication use.
- The member's current treatment plan.

ForwardHealth will deny PA requests for Spinraza if any of the following circumstances are present:

- The member is currently involved in a clinical trial for an SMA drug.
- The member has received treatment with Zolgensma.
- The member has received treatment with Itvisma.
- The member is **currently** receiving treatment with Evrysdi.
- The member is diagnosed with a non-SMN1 variant of SMA.

Initial PA requests for Spinraza to treat SMA may be approved for up to 210 days to allow for up to five doses of Spinraza.

Renewal PA Requests

In addition to meeting the clinical criteria for initial PA request approval, renewal PA requests for Spinraza require the submission of medical records (for example, chart notes, assessment of neurological and motor function) with the most recent results (less than one month prior to the submission of the renewal PA request) documenting a positive clinical response to Spinraza therapy **from pretreatment baseline status** as demonstrated by **one** or more of the following exams:

- HINE that demonstrates the following:
  - Improvement or maintenance of previous improvement of at least a two-point (or maximal score) increase in the ability to kick **or** improvement or maintenance of previous improvement of at least a one-point increase in any other HINE milestone (for example, head control, rolling, sitting, crawling), excluding voluntary grasp
  - Net positive improvement in condition, defined as building on of previous improvement from the pretreatment baseline in a majority of the HINE motor milestones **or** achievement or maintenance of any new motor milestone(s) from the pretreatment baseline when the member would otherwise not be expected to do so (for example, sit unassisted, stand, walk)
- HFMSE that demonstrates **one** of the following:
  - Improvement or maintenance of previous improvement of at least a three-point increase in score from pretreatment baseline
  - Achievement and maintenance of any new motor milestone(s) from pretreatment baseline when the member would otherwise not be expected to do so
- RULM test that demonstrates **one** of the following:
  - Improvement or maintenance of previous improvement of at least a two-point increase in score from pretreatment baseline
  - Achievement and maintenance of any new motor milestone(s) from pretreatment baseline when the member would otherwise not be expected to do so
- CHOP INTEND that demonstrates **one** of the following:
  - Improvement or maintenance of previous improvement of at least a four-point increase in score from pretreatment baseline
  - Achievement and maintenance of any new motor milestone(s) from pretreatment baseline when the member would

otherwise not be expected to do so

Renewal PA requests for Spinraza used to treat SMA may be approved for up to 365 days.

Submitting PA Requests for Spinraza

PA requests for Spinraza must be submitted using the PA/DGA form.

PA requests for Spinraza must be completed, signed, and dated by the prescriber. PA requests for Spinraza should be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for Spinraza may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Zolgensma

Clinical Criteria for Zolgensma

The following clinical criteria must be met and documented for approval of a PA request for Zolgensma:

- Zolgensma is prescribed by a neurologist, pulmonologist, or other physician with expertise in treating SMA and in a manner consistent with the FDA-approved product labeling.
- The member is less than 2 years old.
- The member has SMA, type 1, 2, or 3, which has been confirmed, by genetic testing (5q SMN1: homozygous mutation, homozygous gene deletion, or compound heterozygote).
- The member has **at least two** copies of the SMN2 gene.
- The member does not have advanced SMA including, but not limited to, any of the following:
  - Complete paralysis of the limbs
  - Ventilator dependent for 16 or more hours per day (including non-invasive respiratory support)
- The prescriber submits the most recent pre-treatment anti-AAV9 antibody testing, demonstrating a titer ratio of less than 50 to 1.

A copy of the member's medical records must be submitted and should sufficiently document:

- The information listed in the clinical criteria for PA approval.
- Details regarding previous medication use.
- The member's current treatment plan.

Note: ForwardHealth covers one treatment per lifetime with Zolgensma for pediatric members less than 2 years of age.

ForwardHealth will deny PA requests for Zolgensma if any of the following circumstances are present:

- The member is currently involved in a clinical trial for an SMA drug.
- The member has received prior treatment with Zolgensma.
- The member is **currently** receiving treatment with Spinraza or Evrysdi.
  Note: If a member already has a current approved PA request for Spinraza or Evrysdi, ForwardHealth will end date the

Spinraza or Evrysdi PA request upon approval of Zolgensma.
- The member is diagnosed with a non-SMN1 variant of SMA.
- The member is over 2 years of age.

Submitting PA Requests for Zolgensma

PA requests for Zolgensma must be submitted using the PA/DGA form.

PA requests for Zolgensma must be completed, signed, and dated by the prescriber. PA requests for Zolgensma should be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for Zolgensma may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Topic #23842

Tremfya IV for Crohn's Disease and Ulcerative Colitis

Tremfya IV is a physician-administered drug that requires clinical PA (prior authorization).

All PA requests for Tremfya IV must be submitted with HCPCS (Healthcare Common Procedure Coding System) procedure code J1628 (Injection, guselkumab, 1 mg).

PA requests for Tremfya IV must be completed, signed, and dated by the prescriber. PA requests for Tremfya IV must be submitted using Section V (Clinical Information for Physician-Administered Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) on the PA/PAD (Prior Authorization/Physician-Administered Drug Attachment, F-11034 (07/2022)) form. Clinical documentation supporting the use of Tremfya IV must be submitted with the PA request.

Prescribers are required to submit the completed PA/PAD form and a completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) to ForwardHealth.

PA requests for Tremfya IV may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Conditions for Which PA Requests for Use of Tremfya IV Will Be Considered for Review

ForwardHealth will only consider PA requests for Tremfya IV to treat these conditions:

- Crohn's disease
- Ulcerative colitis

Clinical Criteria for Tremfya IV for Crohn's Disease

Clinical criteria that must be documented for approval of a PA request for Tremfya IV for members with Crohn's disease are **all**

of the following:

- The member has Crohn's disease.
- The member has been diagnosed by a gastroenterologist.
- **Two** of the following are true:
  - The member has taken Cimzia for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Hadlima or Humira for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Selarsdi subQ or Steqeyma subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why Tremfya IV is being requested.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Tremfya IV for members with Crohn's disease. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan
- The member's current weight

If the clinical criteria for Tremfya IV for members with Crohn's disease are met, PA requests will only be approved for three IV induction doses.

Note: A separate PA request must be obtained for maintenance treatment with Tremfya subQ. PA for Tremfya subQ must be obtained through the pharmacy PA process.

Clinical Criteria for Tremfya IV for Ulcerative Colitis

Clinical criteria that must be documented for approval of a PA request for Tremfya IV for members with ulcerative colitis are **all** of the following:

- The member has ulcerative colitis.
- The member has been diagnosed by a gastroenterologist.
- **Two** of the following are true:
  - The member has taken Hadlima or Humira for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Selarsdi subQ or Steqeyma subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Simponi subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Xeljanz or Xeljanz XR for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why Tremfya IV is being requested.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Tremfya IV. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If the clinical criteria for Tremfya IV are met, PA requests will only be approved for three IV induction doses.

Note: A separate PA request must be obtained for maintenance treatment with Tremfya subQ. PA for Tremfya subQ must be obtained through the pharmacy PA process.

Topic #23103

Vyjuvek

Vyjuvek requires clinical PA (prior authorization) and is covered under the pharmacy benefit. Pharmacy providers should submit a pharmacy noncompound drug claim for Vyjuvek.

For questions about the billing or coverage of high cost, orphan, and accelerated approval drugs, providers may contact Provider Services or email dhsorphandrugs@dhs.wisconsin.gov.

Claim Requirements for Vyjuvek

Physician-administered Vyjuvek will be reimbursed separately from physician and clinical services associated with the administration of Vyjuvek.

The pharmacy provider is required to establish a delivery process with the prescriber to ensure that physician-administered Vyjuvek is delivered directly to the prescriber, an agent of the prescriber, or a health care provider designated to administer Vyjuvek to the member. Pharmacy providers may only submit a claim to ForwardHealth for the Vyjuvek that has been administered to a member.

If Vyjuvek has been dispensed for a member but the dose is not administered to the member, the prescriber or health care provider designated to administer Vyjuvek to the member is responsible for notifying the dispensing pharmacy. If ForwardHealth has paid the dispensing pharmacy for any portion of the dispensing of Vyjuvek that is not administered to the member, the dispensing pharmacy is responsible for reversing any claims submitted to ForwardHealth.

Clinical Criteria for Vyjuvek

The following clinical criteria must be met and documented for approval of a PA request for Vyjuvek:

- Vyjuvek must be prescribed by a dermatologist or wound care specialist.
- Vyjuvek must be prescribed in a dose and manner consistent with FDA (Food and Drug Administration)-approved product labeling.
- The member has been diagnosed with dystrophic epidermolysis bullosa with mutation(s) in the collagen type VII alpha 1 chain gene.
- The prescriber must include documentation of at least one cutaneous wound that is appropriate to be treated with Vyjuvek and confirm that the wound does not appear to be infected.
- The prescriber must include documentation of the size of the wound area(s) to be treated and confirm the calculated dose of Vyjuvek will not exceed the recommended maximum weekly dose.
- The prescriber must include documentation that the member's treatment plan includes the appropriate administration of Vyjuvek by someone (a health care professional, caregiver, or the member themselves) who is trained on the wound dressing care requirements for treatment with Vyjuvek.
- The prescriber must include documentation that the member's treatment plan addresses the requirement for Vyjuvek to be properly prepared at a pharmacy for administration to the member's wound(s) within eight hours of mixing of the Vyjuvek gel with the Vyjuvek biological suspension.

Supporting clinical information and a copy of the member's current medical records must be included in all PA requests for

Vyjuvek. The supporting clinical information and the medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If clinical criteria for Vyjuvek are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for Vyjuvek may be approved for up to 365 days. Renewal PA requests must include supporting clinical information and copies of the member's current medical records.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen and demonstrate that the member has had a reduction in wound areas compared to baseline since starting treatment with Vyjuvek.

Submitting PA Requests for Vyjuvek

PA requests for Vyjuvek must be completed, signed, and dated by the prescriber. PA requests for Vyjuvek must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (01/2024)) form. Clinical documentation supporting the use of Vyjuvek must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) to ForwardHealth.

PA requests for Vyjuvek may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Topic #12697

Wearable Cardioverter Defibrillator

Rental of a WCD (wearable cardioverter defibrillator) is a covered service with PA (prior authorization), subject to certain claims submission requirements. The WCD is indicated for members 19 years of age or older who are at high risk for sudden cardiac death. A WCD is used on an outpatient basis and is intended for short-term use under medical supervision.

Approval Criteria

According to Wis. Admin Code § DHS 107.02(3), ForwardHealth has the authority to require and define the terms of PA for DME (durable medical equipment). The following criteria must be met in order for a PA request for the rental of a WCD to be approved:

- The rental of the WCD is medically necessary for a member at high risk of sudden cardiac arrest and meets the American College of Cardiology guidelines for an implantable cardioverter.
- One of the following is true:
  - The member is on the waiting list for a medically necessary heart transplant.
  - The member has an ICD (implantable cardioverter defibrillator) that requires removal due to an infection and is waiting for a new ICD to be inserted.
  - The member has an infectious process or other temporary condition preventing the initial insertion of an ICD.

- The member has a familial or inherited condition with a high risk of life-threatening ventricular tachyarrhythmia (for example, long QT syndrome or hypertrophic cardiomyopathy).
- The member has a documented episode of ventricular fibrillation or a sustained (lasting 30 seconds or longer) ventricular tachyarrhythmia that is not during the first 48 hours after an acute myocardial infarction and is either:
  - Spontaneous.
  - Induced during an electrophysiologic study.

Denial Criteria

ForwardHealth will not cover the rental of a WCD in any of the following circumstances:

- The WCD is not medically necessary (for example, the member received an ICD or heart transplant).
- The member is 18 years of age or younger.
- The member has a vision, hearing, or developmental problem that may interfere with the perception of alarms or messages from the WCD.
- The member is taking medications that would interfere with his or her ability to respond to alarms or messages from the WCD.
- The member is pregnant, breastfeeding, or of childbearing age and is not attempting to prevent pregnancy.
- The member will be exposed to high levels of electromagnetic interference that may prevent the WCD from operating.
- The member is unable or unwilling to wear the device continuously (except when bathing).
- The member has drug-refractory class IV congestive heart failure and is not a candidate for a heart transplant.
- The member has a history of psychiatric disorders that interfere with necessary care and follow-up.
- The member has a reversible triggering factor for ventricular tachycardia or ventricular fibrillation that can be definitely identified, such as ventricular tachyarrhythmia in evolving acute myocardial infarction or an electrolyte abnormality.
- The member has a terminal illness.

Submitting a Prior Authorization Request

DME providers are required to submit the following when requesting PA for the rental of a WCD:

- A completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026))
- A completed PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (02/2024)) (The DME provider is responsible for obtaining the required clinical information from the member's cardiologist to complete the PA/DMEA.)
- A prescription from the member's cardiologist for the WCD
- Documentation supporting the approval criteria indicated in this topic (The DME provider is responsible for obtaining this documentation from the member's cardiologist.)

Note: The cardiologist must be certified by the American Board of Cardiology.

Topic #23357

Zynteglo

Clinical PA (prior authorization) is required for Zynteglo.

If a PA request for Zynteglo is approved, Zynteglo will be covered under the pharmacy benefit.

To bill ForwardHealth for Zynteglo, pharmacy providers should submit a pharmacy noncompound drug claim.

For questions about the billing or coverage of high cost, orphan, and accelerated approval drugs, providers may contact Provider

Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

Additional Requirements for Zynteglo

Zynteglo will be reimbursed separately from physician and clinical services associated with the administration of Zynteglo. The pharmacy provider is required to establish a delivery process with the prescriber to ensure that the physician-administered Zynteglo is delivered directly to the prescriber or an agent of the prescriber.

Pharmacy providers may only submit a claim to ForwardHealth for the Zynteglo that has been administered to a member. If Zynteglo has been dispensed for a member but the dose is not administered to the member, the prescriber is responsible for notifying the dispensing pharmacy. If ForwardHealth has paid the dispensing pharmacy for any portion of the dispensing of Zynteglo that is not administered to the member, the dispensing pharmacy is responsible for reversing any claims submitted to ForwardHealth.

Clinical Criteria for Zynteglo

Clinical criteria that must be documented for approval of a PA request for Zynteglo are **all** of the following:

- Zynteglo must be prescribed by a physician with expertise in treating β-thalassemia at a minimum recommended dose of 5.0×10^6 CD34+ cells/kg of body weight.
- The member has β-thalassemia, which requires regular RBC (red blood cell) transfusions. The member has a history of transfusions for the past two years of at least 100 mL/kg/year of packed RBCs or with eight or more transfusions of packed RBCs per year.
- The member's age is consistent with the FDA (Food and Drug Administration)-approved product labeling for Zynteglo.
- The member will undergo HSC (hematopoietic stem cell) mobilization, apheresis, and myeloablative conditioning. The prescriber must confirm the member has been evaluated for renal and hepatic impairment and HSC transplantation is appropriate for the member.
- The member must have full myeloablative conditioning administered before infusion of Zynteglo. Allow a minimum of 48 hours of washout before Zynteglo infusion.
- The prescriber will complete screening for infectious diseases including HBV (hepatitis B virus), HCV (hepatitis C Virus), HIV 1 and 2 (HIV-1/HIV-2) and HTLV (Human T-lymphotropic virus) 1 and 2 (HTLV-1/HTLV-2) in accordance with clinical guidelines before collection of cells for manufacturing.
- Standard procedures for patient management after HSC transplantation should be followed after Zynteglo infusion.
- The prescriber must manage other concomitant medications (as applicable) consistent with FDA product labeling.
- The member must not take anti-retroviral medications or hydroxyurea for at least one month prior to mobilization, or for the expected duration for elimination of the medications, and until all cycles of apheresis are completed.
- If a member requires anti-retroviral medications for HIV prophylaxis, mobilization and apheresis should be delayed until HIV infection is adequately ruled out.
- The member must stop iron chelation at least seven days prior to myeloablative conditioning. The member will not use myelosuppressive iron chelators for at least six months after Zynteglo infusion.

PA requests for Zynteglo **will not** be approved if the member has any of the following conditions:

- Advanced liver disease (for example, alanine transaminases greater than three times the upper limit of normal, direct bilirubin value greater than 2.5 times the upper limit of normal, baseline prothrombin time [INR (international normalized ratios)] greater than 1.5 times the upper limit of normal, cirrhosis, bridging fibrosis, or active hepatitis)
- Prior or current malignancy or myeloproliferative disorder or significant immunodeficiency disorder
- Prior allogenic or autologous HSC transplant

Submitting PA Requests for Zynteglo

PA requests for Zynteglo must be completed, signed, and dated by the prescriber. PA requests for Zynteglo must be submitted

using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (01/2024)) form. Clinical documentation supporting the use of Zynteglo must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) to ForwardHealth.

PA requests for Zynteglo may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Information is available about general ForwardHealth policy for drugs that require PA approval. This includes what may **not** be considered criteria to support the need for a drug.

Situations Requiring New Requests

Topic #452

Change in Billing Providers

Providers are required to submit a new PA (prior authorization) request when there is a change in billing providers. A new PA request must be submitted with the new billing provider's name and billing provider number. The expiration date of the PA request will remain the same as the original PA request.

Typically, as no more than one PA request is allowed for the same member, the same service(s), and the same dates, the new billing provider is required to send the following to ForwardHealth's PA Unit:

- A copy of the existing PA request, if possible
- A new PA request, including the required attachments and supporting documentation indicating the new billing provider's name and address and billing provider number
- A letter requesting the end-dating of the existing PA request (may be a photocopy) attached to each PA request with the following information:
  - The previous billing provider's name and billing provider number, if known
  - The new billing provider's name and billing provider number
  - The reason for the change of billing provider (The provider may want to confer with the member to verify that the services by the previous provider have ended. The new billing provider may include this verification in the letter.)
  - The requested effective date of the change

Topic #453

Examples

Examples of when a new PA (prior authorization) request must be submitted include the following:

- A provider's billing provider changes.
- A member requests a provider change that results in a change in billing providers.
- A member's enrollment status changes and there is not a valid PA on file for the member's current plan (BadgerCare Plus, Medicaid).

If the **rendering** provider indicated on the PA request changes but the **billing** provider remains the same, the PA request remains valid and a new PA request does **not** need to be submitted.

Topic #454

Services Not Performed Before Expiration Date

Generally, a new PA (prior authorization) request with a new requested start date must be submitted to ForwardHealth if the amount or quantity of prior authorized services is not used by the expiration date of the PA request and the service is still medically necessary.

Submission Options

Topic #12597

278 Health Care Services Review — Request for Review and Response Transaction

Providers may request PA (prior authorization) electronically using the 278 (278 Health Care Services Review — Request for Review and Response) transaction, the standard electronic format for health care service PA requests.

Compliance Testing

Trading partners may conduct compliance testing for the 278 transaction.

After receiving an "accepted" 999 (999 Functional Acknowledgment) for a test 278 transaction, trading partners are required to call the EDI (Electronic Data Interchange) Helpdesk to request the production 278 transaction set be assigned to them.

Submitting Prior Authorization Requests

Submitting an initial PA request using the 278 transaction does not result in a real-time approval and cannot be used to request PA for drugs and diabetic supplies.

After submitting a PA request via a 278 transaction, providers will receive a real-time response indicating whether the transaction is valid or invalid. If the transaction is invalid, the response will indicate the reject reason(s), and providers can correct and submit a new PA request using the 278 transaction. A real-time response indicating a valid 278 transaction will include a PA number and a pending status. The PA request will be placed in a status of "Pending - Fiscal Agent Review."

The 278 transaction does not allow providers to submit supporting clinical information as required to adjudicate the PA request.

Trading partners cannot submit the 278 transaction through PES (Provider Electronic Solutions). In order to submit the 278 transaction, trading partners will need to use their own software or contract with a software vendor.

Topic #7857

Drug Authorization and Policy Override Center

The DAPO (Drug Authorization and Policy Override) Center is a specialized drug help desk for providers to submit PA (prior authorization) requests for weight management agents and to request policy overrides for other drugs or diabetic supplies over the phone. After business hours, providers may leave a voicemail message for DAPO Center staff to return the next business day.

The DAPO Center is staffed by certified pharmacy technicians.

PA Requests and Policy Override Decisions

Providers who call the DAPO Center to request a PA for weight management agents or a policy override for other drugs or diabetic supplies 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, Wisconsin Medicaid, and SeniorCare.

PA Requests

Prescribers or their billing providers are required to be enrolled in Wisconsin Medicaid to submit PA requests to ForwardHealth. Prescribers who are enrolled in Wisconsin Medicaid should indicate their name and NPI (National Provider Identifier) as the billing provider on PA requests. Providers who are not enrolled in Wisconsin Medicaid should indicate the name and NPI of the Medicaid-enrolled billing provider (for example, clinic) with which they are affiliated on PA requests.

When a prescriber, or their designee, calls the DAPO Center, a pharmacy technician will ask them a series of questions based on the Prior Authorization Drug Attachment for Weight Management Agents (F-00163 (07/2026)) form. The prescriber, or their designee, should have all PA information completed on the appropriate PA drug attachment form before calling the DAPO Center to obtain PA. DAPO Center staff will ask for the name of the caller and the caller's credentials. (Is the caller an RN (registered nurse), physician assistant, physician, certified medical assistant, or nurse practitioner?)

Generally by the end of the call, if the 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 for a weight management agent is approved, a decision notice letter will be mailed to the provider. After a PA request for a weight management has been approved, the prescriber should send the prescription to the pharmacy, and the member can pick up the drug. The member does not need to wait for the prescriber to receive the decision notice to pick up the drug at the pharmacy.

Note: If the provider receives a decision notice letter for a drug for which they 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 their 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, they may submit the PA request to ForwardHealth for review by a pharmacist. The prescriber is required to submit a PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) and the applicable PA drug attachment form with the additional medical documentation. Documentation may be submitted to ForwardHealth through the Portal or by fax or mail.

Providers with questions about pharmacy policies and procedures may continue to call Provider Services.

Policy Override Decisions

When calling the DAPO Center to request a policy override, the following information must be provided:

- Member information
- Provider information
- Prescription information
- The reason for the override request

Topic #455

Fax

Faxing of all PA (prior authorization) requests to ForwardHealth may eliminate one to three days of mail time. These are the recommendations to avoid delays when faxing PA requests:

- Providers should follow the PA fax procedures.
- Providers should **not** fax the same PA request more than once.

- Providers should **not** fax **and** mail the same PA request. This causes delays in processing.

PA requests containing X-rays, dental molds, or photos as documentation must be mailed; they may not be faxed.

To help safeguard the confidentiality of member health care records, providers should include a fax transmittal form containing a confidentiality statement as a cover sheet to all faxed PA requests. The Prior Authorization Fax Cover Sheet (F-01176 (12/2025)) 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 these guidelines/procedures listed in the next sections.

Fax Transmittal Cover Sheet

The completed fax transmittal cover sheet must include:

- 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 at 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.

Incomplete Fax Transmissions

If the pages listed on the initial cover sheet do not all transmit (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 this 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:

- Attach a completed cover sheet with the number of pages of the fax.
- Resend the entire original fax transmission and the additional information requested by the fax clerk to 608-221-8616.

General Guidelines

When faxing information to ForwardHealth, providers should not reduce the size of the PA/RF (Prior Authorization Request

Form, F-11018 (05/2013)) or the PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (05/13)) to fit on the bottom half of the cover page. This makes the PA request difficult to read and leaves no space for consultants to write a response if needed or to sign the request.

If a photocopy of the original PA request and attachments is faxed, the provider should make sure these copies are clear and legible. If the information is not clear, it will be returned to the provider.

If the provider does not indicate his or her fax number, ForwardHealth will mail the decision back to the provider.

ForwardHealth will attempt to fax a response to the PA request to a provider three times. If unsuccessful, the PA request will be mailed to the provider.

If providers are not sure if an entire fax was sent, they should call ForwardHealth's fax clerk at 608-224-6124, to inquire about the status of the fax.

Prior Authorization Request Deadlines

Faxing a PA request eliminates one to three days of mail time. However, the adjudication time of the PA request has not changed. All actions regarding PA requests are made within the predetermined time frames.

Faxed PA requests received after 1 p.m. will be considered as received the following business day. Faxed PA requests received on a Saturday, Sunday, or holiday will be processed on the next business day.

Avoid Duplicating Prior Authorization Requests

After faxing a PA request, providers should not send the original paperwork by mail. Mailing the original paperwork after faxing the PA request will create duplicate PA requests in the system and may result in a delay of several days to process the faxed PA request.

Refaxing a PA request before the previous PA request has been returned will also create duplicate PA requests and may result in delays.

Response Back from ForwardHealth

Once ForwardHealth reviews a PA request, ForwardHealth will fax one of three responses back to the provider:

- "Your approved, modified, or denied PA request(s) is attached."
- "Your PA request(s) requires additional information (see attached). Resubmit the entire PA request, including the attachments, with the requested additional information."
- "Your PA request(s) has missing pages and/or is illegible (see attached). Resubmit the entire PA request, including the attachments."

Resubmitting Prior Authorization Requests

When resubmitting a faxed PA request, providers are required to resubmit the faxed copy of the PA request, including attachments. This will allow the provider to obtain the earliest possible grant date for the PA request (apart from backdating for retroactive enrollment). If any attachments or additional information that was requested is received without the rest of the PA request, the information will be returned to the provider.

Topic #458

ForwardHealth Portal Prior Authorization

All providers can use the PA (prior authorization) features on the ForwardHealth Portal (the Portal) to:

- Submit PA requests and amendments for all services that require PA.
- Save a partially completed PA request and return at a later time to finish completing it.
- Upload PA attachments and additional supporting clinical documentation for PA requests.
- Receive decision notice letters and returned provider review letters.
- Correct returned PA requests and PA amendment requests.
- Change the status of a PA request from "Suspended" to "Pending."
- Submit additional supporting documentation for a PA request that is in "Suspended" or "Pending" status.
- Search and view previously submitted PA requests or saved PA requests.
- Print a PA cover sheet.

Only pharmacy providers can use the PA features on the Portal to:

- Correct returned PA requests and PA amendment requests.
- Change the status of a PA request from "Suspended" to "Pending."

Submitting PA Requests and Amendment Requests

Providers can submit PA requests for all services that require PA to ForwardHealth via the secure Provider area of the Portal. To save time, providers can copy and paste information from plans of care and other medical documentation into the appropriate fields on the PA request. Except for those providers exempt from NPI (National Provider Identifier) requirements, NPI and related data are required on PA requests submitted via the Portal.

Note: If a PA request is urgent, providers must check the Urgent checkbox when submitting the request in the ForwardHealth Portal.

When completing PA attachments on the Portal, providers can take advantage of an Additional Information field at the end of the PA attachment that holds up to five pages of text that may be needed.

Providers may also submit amendment requests via the Portal for PA requests with a status of "Approved" or "Approved with Modifications."

Saving Partially Completed PA Requests

Providers do not have to complete PA requests in one session; they can save partially completed PA requests at any point after the Member Information page has been completed by clicking on the Save and Complete Later button, which is at the bottom of each page. There is no limit to how many times PA requests can be saved.

Providers can complete partially saved PA requests at a later time by logging in to the secure Provider area of the Portal, navigating to the Prior Authorization home page, and clicking on the Complete a Saved PA Request link. This link takes the provider to a Saved PA Requests page containing all of the provider's PA requests that have been saved.

Once on the Saved PA Requests page, providers can select a specific PA request and choose to either continue completing it or delete it.

Note: The ability to save partially completed PA requests is only applicable to new PA requests. Providers cannot save partially completed PA amendments or corrections to returned PA requests or amendments.

30 Calendar Days to Submit or Re-Save PA Requests

Providers must submit or re-save PA requests within 30 calendar days of the date the PA request was last saved. After 30 calendar days of inactivity, a PA request is automatically deleted, and the provider has to re-enter the entire PA request.

The Saved PA Requests page includes a list of deleted PA requests. This list is for information purposes only and includes saved PA requests that have been deleted due to inactivity (it does **not** include PA requests deleted by the provider). Neither providers nor ForwardHealth are able to retrieve PA requests that have been deleted.

Submitting Completed PA Requests

ForwardHealth's initial receipt of a PA request occurs when the PA request is submitted on the Portal. Normal backdating policy applies based on the date of initial receipt, not on the last saved date. Providers receive a confirmation of receipt along with a PA number once a PA request is submitted on the Portal.

PA Attachments on the Portal

Almost all PA request attachments can be completed and submitted on the Portal. When providers are completing PA requests, the Portal presents the necessary attachments needed for that PA request. For example, if a provider is completing a PA request for physician-administered drugs, the Portal will prompt a PA/PAD (Prior Authorization/Physician-Administered Drug Attachment, F-11034 (07/2022)) and display the form for the provider to complete. Certain PA attachments cannot be completed online or uploaded.

Providers may also upload an electronically completed version of the paper PA attachment form. However, when submitting a PA attachment electronically, ForwardHealth recommends completing the PA attachment online as opposed to uploading an electronically completed version of the paper attachment form to reduce the chances of the PA request being returned for clerical errors.

All PA request attachment forms are available on the Portal. Pharmacy providers may download and print to submit by fax or mail. If pharmacy PA attachment(s) are mailed or faxed, a system-generated Portal PA Cover Sheet (F-11159 (07/12)) must be printed and sent with the attachment to ForwardHealth for processing. When ForwardHealth receives the PA attachment(s) by mail or fax, they will be matched up with the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) that was completed on the Portal.

Note: If the cover sheet could not be generated while submitting the PA request due to technical difficulties, providers can print the cover sheet from the main Portal PA page.

Before submitting any PA request documents, providers should save or print a copy for their records. Once the PA request is submitted, it cannot be retrieved for further editing.

As a reminder, ForwardHealth does not mail back any PA request documents submitted by providers.

Additional Supporting Clinical Documentation

ForwardHealth accepts additional supporting clinical documentation when the information cannot be indicated on the required PA request forms and is pertinent for processing the PA request or PA amendment request. Providers must submit additional supporting clinical information for PA requests or PA amendment requests electronically.

Providers can choose to upload electronic supporting information through the Portal in the following formats:

- JPEG (.jpg or .jpeg)
- PDF (.pdf)

- Rich Text Format (.rtf)
- Text File (.txt)
- OrthoCAD (.3dm) and 3Shape Ortho System (.dcm, .stl, and .ply) (for dental providers)

Make sure files are stored with the correct extension:

- JPEG files are stored with a ".jpg" or ".jpeg" extension.
- PDF files are stored with a ".pdf" extension.
- Rich text format files are stored with an ".rtf" extension.
- Text files are stored with a ".txt" extension.
- Dental OrthoCAD files are stored with a ".3dm" extension.
- Dental 3Shape Ortho System files are stored with ".dcm", ".stl", or ".ply" extensions.

Microsoft Word files (.docx or .doc) cannot be uploaded but can be saved and uploaded in Rich Text Format or Text File formats.

In addition, providers can upload additional supporting clinical documentation via the Portal when submitting a PA amendment request.

Pharmacy providers may correct a PA request or PA amendment that is in a "Returned — Provider Review" status.

ForwardHealth will return pharmacy PA requests and PA amendments requests when the additional documentation could have been indicated on the PA/RF or PA/DRF and PA attachments or when the pertinent information is difficult to find.

If pharmacy providers submit supporting clinical information via mail or fax, pharmacy providers are prompted to print a system-generated Portal PA Cover Sheet to be sent with the information to ForwardHealth for processing. Pharmacy providers must list the additional supporting information on the Portal PA Cover Sheet.

"Suspended" PA Requests for Pharmacy Providers

For pharmacy PA requests in a "Suspended" status, the provider has the option to:

- Change a PA request status from "Suspended" to "Pending."
- Submit additional documentation for a PA request that is in "Suspended" or "Pending" status.

Changing a PA Request From "Suspended" to "Pending" for Pharmacy Providers

Pharmacy providers have the option of changing a PA request status from "Suspended — Provider Sending Info" to "Pending" if the pharmacy provider determines that additional information will not be submitted. Changing the status from "Suspended — Provider Sending Info" to "Pending" will allow the PA request to be processed without waiting for additional information to be submitted. The pharmacy provider can change the status by searching for the suspended PA request, checking the box indicating that the PA request is ready for processing without additional documentation, and clicking the Submit button to allow the PA request to be processed by ForwardHealth. There is an optional free form text box, which allows pharmacy providers to explain or comment on why the PA request can be processed.

Submitting Additional Supporting Clinical Documentation for a PA Request in "Suspended" or "Pending" Status for Pharmacy Providers

There is an Upload Documents for a PA link on the PA home page in the provider secured Home Page. By selecting that link, pharmacy providers have the option of submitting additional supporting clinical documentation for a PA request that is in "Suspended" or "Pending" status. When submitting additional supporting clinical documentation for a PA request that is in "Suspended" status, pharmacy providers can choose to have ForwardHealth begin processing the PA request or to keep the PA

request suspended. PA requests in a "Pending" status are processed regardless.

Note: When the PA request is in a "Pending" status and the pharmacy provider uploads additional supporting clinical documentation, there may be up to a four-hour delay before the documentation is available to ForwardHealth in the system. If the uploaded information was received after the PA request was processed and the PA request was returned for missing information, the pharmacy provider may resubmit the PA request stating that the missing information was already uploaded.

Topic #456

Mail

Any type of PA (prior authorization) request may be submitted on paper. Providers may mail completed PA requests, amendments to PA requests, and requests to enddate a PA request to ForwardHealth at the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

Provider Enrollment and Ongoing Responsibilities

7

Archive Date:10/01/2026

Provider Enrollment and Ongoing Responsibilities:Documentation

Topic #6277

1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than $600, per IRS (Internal Revenue Service) regulations. One 1099 Miscellaneous form per financial payer and per tax identification number is generated, regardless of how many provider IDs or NPIs (National Provider Identifier) share the same tax identification number. For example, a provider who conducts business with both Medicaid and WCDP (Wisconsin Chronic Disease Program) will receive separate 1099 Miscellaneous forms for each program.

The 1099 Miscellaneous forms are sent to the address designated as the 1099 mailing address.

Topic #1640

Availability of Records to Authorized Personnel

Wisconsin DHS (Department of Health Services) has the right to inspect, review, audit, and reproduce provider records pursuant to Wis. Admin. Code § DHS 106.02(9)(e). DHS periodically requests provider records for compliance audits to match information against ForwardHealth's information on paid claims, PA (prior authorization) requests, and enrollment. These records include, but are not limited to, medical/clinical and financial documents. Providers are obligated to ensure that the records are released to an authorized DHS staff member(s).

If Wisconsin Medicaid requires a provider to submit hard copies of records instead of scanning or accepting electronic records during a compliance audit, DHS reimburses providers $0.06 per page. A letter of request for records from DHS will be sent to a provider when records are required, with instructions on how to submit records electronically or if physical records are required.

Reimbursement is not made for other reproduction costs included in the provider agreement between DHS and a provider, such as reproduction costs for submitting PA requests and claims.

Also, state-contracted MCOs (managed care organizations), including HMOs and SSI HMOs, are not reimbursed for the reproduction costs covered in their contract with DHS.

The reproduction of records requested by the PRO (Peer Review Organization) under contract with DHS is reimbursed at a rate established by the PRO.

Topic #200

Confidentiality and Proper Disposal of Records

ForwardHealth supports member rights regarding the confidentiality of health care and other related records, including an applicant or member's billing information or medical claim records. An applicant or member has a right to have this information safeguarded, and the provider is obligated to protect that right. Use or disclosure of any information concerning an applicant or member (including an applicant or member's billing information or medical claim records) for any purpose not connected with program administration is prohibited unless authorized by the applicant or member (program administration includes contacts with

third-party payers that are necessary for pursuing third-party payment and the release of information as ordered by the court).

Federal HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy and Security regulations establish requirements regarding the confidentiality and proper disposal of health care and related records containing PHI (protected health information). These requirements apply to all providers (who are considered "covered entities") and their business associates who create, retain, and dispose of such records.

For providers and their business partners who are not subject to HIPAA, Wisconsin confidentiality laws have similar requirements pertaining to proper disposal of health care and related records.

HIPAA Privacy and Security Regulations

Definition of Protected Health Information

As defined in the HIPAA privacy and security regulations, PHI is protected health information (including demographic information) that:

- Is created, received, maintained, or transmitted in any form or media.
- Relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the payment for the provision of health care to an individual.
- Identifies the individual or provides a reasonable basis to believe that it can be used to identify the individual.

A member's name combined with their member identification number or Social Security number is an example of PHI.

Requirements Regarding "Unsecured" Protected Health Information

Title XIII of the American Recovery and Reinvestment Act of 2009 (also known as the HITECH (Health Information Technology for Economic and Clinical Health) Act) included a provision that significantly expanded the scope, penalties, and compliance challenges of HIPAA. This provision imposes new requirements on covered entities and their business associates to notify patients, the federal government, and the media of breaches of "unsecured" PHI (refer to 45 C.F.R. Parts 160 and 164 and § 13402 of the HITECH Act).

Unsecured PHI is PHI that has not been rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of physical destruction approved by the U.S. HHS (Department of Health and Human Services). According to HHS, destruction is the only acceptable method for rendering PHI unusable, unreadable, or indecipherable.

As defined by federal law, unsecured PHI includes information in **any** medium, not just electronic data.

Actions Required for Proper Disposal of Records

Under the HIPAA privacy and security regulations, health care and related records containing PHI must be disposed of in such a manner that they cannot be reconstructed. This includes ensuring that the PHI is secured (for example, rendered unusable, unreadable, or indecipherable) prior to disposal of the records.

To secure PHI, providers and their business associates are required to use one of the following destruction methods approved by the HHS:

- Paper, film, labels, or other hard copy media should be shredded or destroyed such that the PHI cannot be read or otherwise reconstructed.
- Electronic media should be cleared, purged, or destroyed such that the PHI cannot be retrieved according to National Institute of Standards and Technology Special Publication 800-88, Guidelines for Media Sanitization, which can be found on the NIST (National Institute of Standards and Technology) website.

For more information regarding securing PHI, providers may refer to Health Information Privacy on the HHS website.

Wisconsin Confidentiality Laws

Wis. Stat. § 134.97 requires providers and their business partners who are not subject to HIPAA regulations to comply with Wisconsin confidentiality laws pertaining to the disposal of health care and related records containing PHI.

Wis. Stat. § 146.836 specifies that the requirements apply to "all patient health care records, including those on which written, drawn, printed, spoken, visual, electromagnetic or digital information is recorded or preserved, regardless of physical form or characteristics." Paper **and** electronic records are subject to Wisconsin confidentiality laws.

"Personally Identifiable Data" Protected

According to Wis. Stat. § 134.97(1)(e), the types of records protected are those containing "personally identifiable data."

As defined by the law, personally identifiable data is information about an individual's medical condition that is not considered to be public knowledge. This may include account numbers, customer numbers, and account balances.

Actions Required for Proper Disposal of Records

Health care and related records containing personally identifiable data must be disposed of in such a manner that no unauthorized person can access the personal information. For the period of time between a record's disposal and its destruction, providers and their business partners are required to take actions that they reasonably believe will ensure that no unauthorized person will have access to the personally identifiable data contained in the record.

Businesses Affected

Wis. Stat.§§ 134.97 and 134.98, governing the proper disposal of health care and related records, apply to medical businesses as well as financial institutions and tax preparation businesses. For the purposes of these requirements, a medical business is any for-profit or nonprofit organization or enterprise that possesses information — other than personnel records — relating to a person's physical or mental health, medical history, or medical treatment. Medical businesses include sole proprietorships, partnerships, firms, business trusts, joint ventures, syndicates, corporations, limited liability companies, or associates.

Continuing Responsibilities for All Providers After Ending Participation

Ending participation in a ForwardHealth program does not end a provider's responsibility to protect the confidentiality of health care and related records containing PHI.

Providers who no longer participate in a ForwardHealth program are responsible for ensuring that they and their business associates/partners continue to comply with all federal and state laws regarding protecting the confidentiality of members' PHI. Once record retention requirements expire, records must be disposed of in such a manner that they cannot be reconstructed — according to federal and state regulations — in order to avoid penalties.

All ForwardHealth providers and their business associates/partners who cease practice or go out of business should ensure that they have policies and procedures in place to protect all health care and related records from any unauthorized disclosure and use.

Penalties for Violations

Any covered entity provider or provider's business associate who violates federal HIPAA regulations regarding the confidentiality and proper disposal of health care and related records may be subject to criminal and/or civil penalties, including any or all of the following:

- Fines up to $1.5 million per calendar year
- Jail time
- Federal HHS Office of Civil Rights enforcement actions

For entities not subject to HIPAA, Wis. Stat. § 34.97(4) imposes penalties for violations of confidentiality laws. Any provider or provider's business partner who violates Wisconsin confidentiality laws may be subject to fines up to $1,000 per incident or occurrence.

For more specific information on the penalties for violations related to members' health care records, providers should refer to § 13410(d) of the HITECH Act, which amends 42 USC § 1320d-5, and Wis. Stat. §§ 134.97(3), (4) and 146.84.

Topic #201

Financial Records

According to Wis. Admin. Code § DHS 106.02(9)(c), a provider is required to maintain certain financial records in written or electronic form.

Topic #202

Medical Records

A dated clinician's signature must be included in all medical notes. According to Wis. Admin. Code § DHS (Department of Health Services) 106.02(9)(b), a provider is required to include certain written documentation in a member's medical record.

Topic #199

Member Access to Records

Providers are required to allow members access to their health care records, including those related to ForwardHealth services, maintained by a provider in accordance with Wisconsin Statutes, excluding billing statements.

Fees for Health Care Records

Per Wis. Stat. § 146.83, providers may charge a fee for providing one set of copies of health care records to members who are enrolled in Wisconsin Medicaid or BadgerCare Plus programs on the date of the records request. This applies regardless of the member's enrollment status on the DOS (dates of service) contained within the health care records.

Per Wis. Stat. § 146.81(4), health care records are all records related to the health of a patient prepared by, or under the supervision of, a health care provider.

Providers are limited to charging members enrolled in state-funded health care programs 25% of the applicable fees for providing one set of copies of the member's health care records.

Note: A provider may charge members 100% of the applicable fees for providing a second or additional set of copies of the member's health care records.

Wisconsin DHS (Department of Health Services) adjusts the amounts a provider may charge for providing copies of a member's health care records yearly per Wis. Stat. § 146.83(3f)(c).

Topic #16157

Policy Requirements for Use of Electronic Signatures on Electronic Health Records

For ForwardHealth policy areas where a signature is required, electronic signatures are acceptable as long as the signature meets the requirements. When ForwardHealth policy specifically states that a handwritten signature is required, an electronic signature will not be accepted. When ForwardHealth policy specifically states that a written signature is required, an electronic signature will be accepted.

Reimbursement for services paid to providers who do not meet all electronic signature requirements may be subject to recoupment.

Electronic Signature Definition

An electronic signature, as stated in Wis. Stat. § 137.11(8), is "an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record."

Some examples include:

- Typed name (performer may type their complete name)
- Number (performer may type a number unique to them)
- Initials (performer may type initials unique to them)

All examples above must also meet all of the electronic signature requirements.

Benefits of Using Electronic Signatures

The use of electronic signatures will allow providers to:

- Save time by streamlining the document signing process.
- Reduce the costs of postage and mailing materials.
- Maintain the integrity of the data submitted.
- Increase security to aid in non-repudiation.

Electronic Signature Requirements

By following the general electronic signature requirements below, the use of electronic signatures provides a secure alternative to written signatures. These requirements align with HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule guidelines.

General Requirements

When using an electronic signature, all of the following requirements must be met:

- The electronic signature must be under the sole control of the rendering provider. Only the rendering provider or designee has the authority to use the rendering provider's electronic signature. Providers are required to maintain documentation that shows the electronic signature that belongs to each rendering provider if a numbering or initial system is used (for example, what number is assigned to a specific rendering provider). This documentation must be kept confidential.

- The provider is required to have current policies and procedures regarding the use of electronic signatures. Wisconsin DHS (Department of Health Services) recommends the provider conduct an annual review of policies and procedures with those using electronic signatures to promote ongoing compliance and to address any changes in the policies and procedures.
- The provider is required to conduct or review a security risk analysis in accordance with the requirements under 45 C.F.R. s. 164.308(a)(1).
- The provider is required to implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
- The provider is required to establish administrative, technical, and physical safeguards in compliance with the HIPAA Security Rule.

Electronic Health Record Signature Requirements

An EHR (electronic health record) that utilizes electronic signatures must meet the following requirements:

- The certification and standard criteria defined in the Health Information Technology Initial Set of Standards, Implementation Specifications, Certification Criteria for Electronic Health Record Technology Final Rule (45 C.F.R. Part 170) and any revisions including, but not limited to, the following:
  - Assign a unique name and/or number for identifying, tracking user identity, and establishing controls that permit only authorized users to access electronic health information.
  - Record actions related to electronic health information according to the standard set forth in 45 C.F.R. s. 170.210.
  - Enable a user to generate an audit log for a specific time period. The audit log must also have the ability to sort entries according to any of the elements specified in the standard 45 C.F.R. s. 170.210.
  - Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.
  - Record the date, time, patient identification, and user identification when electronic health information is created, modified, accessed, or deleted. An indication of which action(s) occurred and by whom must also be recorded.
  - Use a hashing algorithm with a security strength equal to or greater than SHA-1 (Secure Hash Algorithm 1) as specified by the NIST (National Institute of Standards and Technology) in FIPS PUB 180-3 (October 2008) to verify that electronic health information has not been altered. (Providers unsure whether or not they meet this guideline should contact their IT (Information Technology) and/or security/privacy analyst.)
- Ensure the EHR provides:
  - Nonrepudiation (assurance that the signer cannot deny signing the document in the future).
  - User authentication (verification of the signer's identity at the time the signature was generated).
  - Integrity of electronically signed documents (retention of data so that each record can be authenticated and attributed to the signer).
  - Message integrity (certainty that the document has not been altered since it was signed).
  - Capability to convert electronic documents to paper copy. (The paper copy must indicate the name of the individual who electronically signed the form as well as the date electronically signed.)
- Ensure electronically signed records created by the EHR have the same back-up and record retention requirements as paper records.

Topic #203

Preparation and Maintenance of Records

All providers who receive payment from Wisconsin Medicaid, including state-contracted MCOs (managed care organizations), are required to maintain records that fully document the basis of charges upon which all claims for payment are made, according to Wis. Admin. Code § DHS 106.02(9)(a). This required maintenance of records is typically required by any third-party insurance company and is not unique to ForwardHealth.

Topic #204

Record Retention

Providers are required to retain documentation, including medical and financial records, for a period of not less than five years from the date of payment, except RHCs (rural health clinics), which are required to retain records for a minimum of six years from the date of payment.

According to Wis. Admin. Code § DHS 106.02(9)(d), providers are required to retain all evidence of billing information.

Ending participation as a provider does not end a provider's responsibility to retain and provide access to fully maintained records unless an alternative arrangement of record retention and maintenance has been established.

Maintaining Confidentiality of Records

Ending participation in a ForwardHealth program does not end a provider's responsibility to protect the confidentiality of health care and related records containing PHI (protected health information).

Providers who no longer participate in a ForwardHealth program are responsible for ensuring that they and their business associates/partners continue to comply with all federal and state laws regarding protecting the confidentiality of members' PHI. Once record retention requirements expire, records must be disposed of in such a manner that they cannot be reconstructed—according to federal and state regulations—in order to avoid penalties. For more information on the proper disposal of records, refer to Confidentiality and Proper Disposal of Records.

All ForwardHealth providers and their business associates/partners who cease practice or go out of business should ensure that they have policies and procedures in place to protect all health care and related records from any unauthorized disclosure and use.

Reviews and Audits

Wisconsin DHS (Department of Health Services) periodically reviews provider records. DHS has the right to inspect, review, audit, and photocopy the records. Providers are required to permit access to any requested record(s), whether in written, electronic, or micrographic form.

Topic #205

Records Requests

Requests for billing or medical claim information regarding services reimbursed by Wisconsin Medicaid may come from a variety of individuals including attorneys, insurance adjusters, and members. Providers are required to notify ForwardHealth when releasing billing information or medical claim records relating to charges for covered services except in the following instances:

- When the member is a dual eligible (for example, member is eligible for both Medicare and Wisconsin Medicaid or BadgerCare Plus) and is requesting materials pursuant to **Medicare** regulations.
- When the provider is attempting to exhaust all existing health insurance sources prior to submitting claims to ForwardHealth.

Request From a Member or Authorized Person

If the request for a member's billing information or medical claim records is from a member or authorized person acting on behalf of a member, the provider is required to do the following:

1. Send a copy of the requested billing information or medical claim records to the requestor.

2. Send a letter containing the following information to ForwardHealth:
    - Member's name
    - Member's ForwardHealth identification number or SSN (Social Security number), if available
    - Member's DOB (date of birth)
    - DOS (date of service)
    - Entity requesting the records, including name, address, and telephone number

    The letter must be sent to the following address:

    Wisconsin Casualty Recovery—HMS
    Ste 100
    5615 Highpoint Dr
    Irving TX 75038-9984

Request From an Attorney, Insurance Company, or Power of Attorney

If the request for a member's billing information or medical claim records is from an attorney, insurance company, or power of attorney, the provider is required to do the following:

1. Obtain a release signed by the member or authorized representative.
2. Furnish the requested material to the requester, marked BILLED TO FORWARDHEALTH or TO BE BILLED TO FORWARDHEALTH, with a copy of the release signed by the member or authorized representative. Approval from ForwardHealth is not necessary.
3. Send a copy of the material furnished to the requestor, along with a copy of their original request and medical authorization release to:

    Wisconsin Casualty Recovery—HMS
    Ste 100
    5615 Highpoint Dr
    Irving TX 75038-9984

Request for Information About a Member Enrolled in a State-Contracted Managed Care Organization

If the request for a member's billing information or medical claim records is for a member enrolled in a state-contracted MCO (managed care organization), the provider is required to do the following:

1. Obtain a release signed by the member or authorized representative.
2. Send a copy of the letter requesting the information, along with the release signed by the member or authorized representative, directly to the MCO.

The MCO makes most benefit payments and is entitled to any recovery that may be available.

Request for a Statement From a Dual Eligible

If the request is for an itemized statement from a dual eligible, pursuant to HR 2015 (Balanced Budget Act of 1997) § 4311, a dual eligible has the right to request and receive an itemized statement from their Medicare-enrolled health care provider. The Act requires the provider to furnish the requested information to the member. The Act does **not** require the provider to notify ForwardHealth.

Topic #1646

Release of Billing Information to Government Agencies

Providers are permitted to release member information without informed consent when a written request is made by Wisconsin DHS (Department of Health Services) or the federal HHS (Department of Health and Human Services) to perform any function related to program administration, such as auditing, program monitoring, and evaluation.

Providers are authorized under Wisconsin Medicaid confidentiality regulations to report suspected misuse or abuse of program benefits to DHS, as well as to provide copies of the corresponding patient health care records.

Ongoing Responsibilities

Topic #220

Accommodating Members With Disabilities

All providers, including ForwardHealth providers, operating an existing public accommodation have requirements under Title III of the Americans with Disabilities Act of 1990 (nondiscrimination).

Topic #219

Civil Rights Compliance (Nondiscrimination)

Providers are required to comply with all federal laws relating to Title XIX of the Social Security Act and state laws pertinent to ForwardHealth, including:

- Title VI and VII of the Civil Rights Act of 1964
- The Age Discrimination Act of 1975
- Section 504 of the Rehabilitation Act of 1973
- The ADA (Americans With Disabilities Act) of 1990

These laws require that all health care benefits under ForwardHealth be provided on a nondiscriminatory basis. No applicant or member can be denied participation in ForwardHealth or be denied benefits or otherwise subjected to discrimination in any manner under ForwardHealth on the basis of race, color, national origin or ancestry, sex, religion, age, disability, or association with a person with a disability.

Any of the following actions may be considered discriminatory treatment when based on race, color, national origin, disability, or association with a person with a disability:

- Denial of aid, care, services, or other benefits
- Segregation or separate treatment
- Restriction in any way of any advantage or privilege received by others (There are some program restrictions based on eligibility classifications.)
- Treatment different from that given to others in the determination of eligibility
- Refusing to provide an oral language interpreter to persons who are considered LEP (limited English proficient) at no cost to the LEP individual in order to provide meaningful access
- Not providing translation of vital documents to the LEP groups who represent 5% or 1,000, whichever is smaller, in the provider's area of service delivery

Note: Limiting practice by age is not age discrimination and specializing in certain conditions is not disability discrimination. For further information, see 45 C.F.R. Part 91.

Providers are required to be in compliance with the previously mentioned laws as they are currently in effect or amended. Providers who employ 25 or more employees and receive $25,000 or more annually in Medicaid reimbursement are also required to comply with the Wisconsin DHS (Department of Health Services) Affirmative Action and Civil Rights Compliance Plan requirements. Providers that employ fewer 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 can get 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
201 E Washington Ave Room B300
PO Box 7850
Madison WI 53707-7850

For more information on the acts protecting members from discrimination, refer to the civil rights compliance information in the Enrollment and Benefits booklet. The booklet is given to new ForwardHealth members by local county or Tribal agencies. Potential ForwardHealth members can request the booklet by calling Member Services.

Title VI of the Civil Rights Act of 1964

This act requires that all benefits be provided on a nondiscriminatory basis and that decisions regarding the provision of services be made without regard to race, color, or national origin. Under this act, the following actions are prohibited, if made on the basis of race, color, or national origin:

- Denying services, financial aid, or other benefits that are provided as a part of a provider's program
- Providing services in a manner different from those provided to others under the program
- Aggregating or separately treating clients
- Treating individuals differently in eligibility determination or application for services
- Selecting a site that has the effect of excluding individuals
- Denying an individual's participation as a member of a planning or advisory board
- Any other method or criteria of administering a program that has the effect of treating or affecting individuals in a discriminatory manner

Title VII of the Civil Rights Act of 1964

This act prohibits differential treatment, based solely on a person's race, color, sex, national origin, or religion, in the terms and conditions of employment. These conditions or terms of employment are failure or refusal to hire or discharge compensation and benefits, privileges of employment, segregation, classification, and the establishment of artificial or arbitrary barriers to employment.

Federal Rehabilitation Act of 1973, Section 504

This act prohibits discrimination in both employment and service delivery based solely on a person's disability.

This act requires the provision of reasonable accommodations where the employer or service provider cannot show that the accommodation would impose an undue hardship in the delivery of the services. A reasonable accommodation is a device or service modification that will allow the disabled person to receive a provider's benefits. An undue hardship is a burden on the program that is not equal to the benefits of allowing that handicapped person's participation.

A handicapped person means any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

In addition, Section 504 requires "program accessibility," which may mean building accessibility, outreach, or other measures that allow for full participation of the handicapped individual. In determining program accessibility, the program or activity will be viewed in its entirety. In choosing a method of meeting accessibility requirements, the provider shall give priority to those methods that offer a person who is disabled services that are provided in the most integrated setting appropriate.

Americans With Disabilities Act of 1990

Under Title III of the ADA of 1990, any provider that operates an existing public accommodation has four specific requirements:

1. Remove barriers to make their goods and services available to and usable by people with disabilities to the extent that it is readily achievable to do so (to the extent that needed changes can be accomplished without much difficulty or expense)
2. Provide auxiliary aids and services so that people with sensory or cognitive disabilities have access to effective means of communication, unless doing so would fundamentally alter the operation or result in undue burdens
3. Modify any policies, practices, or procedures that may be discriminatory or have a discriminatory effect, unless doing so would fundamentally alter the nature of the goods, services, facilities, or accommodations
4. Ensure that there are no unnecessary eligibility criteria that tend to screen out or segregate individuals with disabilities or limit their full and equal enjoyment of the place of public accommodation

Age Discrimination Act of 1975

The Age Discrimination Act of 1975 prohibits discrimination on the basis of age in programs and activities receiving federal financial assistance. The act, which applies to all ages, permits the use of certain age distinctions and factors other than age that meet the act's requirements.

Topic #198

Contracted Staff

Under a few circumstances (for example, personal care, case management services), providers may contract with non-Medicaid-enrolled agencies for services. Providers are legally, programmatically, and fiscally responsible for the services provided by their contractors and their contractors' services.

When contracting services, providers are required to ensure contracted agencies are qualified to provide services, meet all ForwardHealth and program requirements, and maintain records in accordance with the requirements for the provision of services.

Medicaid requirements do not relieve contracted agencies of their own regulatory requirements. Contracted agencies are required to continue to meet their own regulatory requirements, in addition to ForwardHealth requirements.

Providers are also responsible for informing a contracted agency of ForwardHealth requirements. Providers should refer those with whom they contract for services to ForwardHealth publications for program policies and procedures. ForwardHealth references and publications include, but are not limited to, the following:

- Wisconsin Administrative Code
- ForwardHealth Updates
- The Online Handbook

Providers should encourage contracted agencies to visit the ForwardHealth Portal regularly for the most current information.

Topic #216

Examples of Ongoing Responsibilities

Responsibilities for which providers are held accountable are described throughout the Online Handbook. Medicaid-enrolled providers have responsibilities that include, but are not limited to, the following:

- Providing the same level and quality of care to ForwardHealth members as private-pay patients
- Complying with all state and federal laws related to ForwardHealth
- Obtaining PA (prior authorization) for services, when required
- Notifying members in advance if a service is not covered by ForwardHealth and the provider intends to collect payment from the member for the service
- Maintaining accurate medical and billing records
- Retaining preparation, maintenance, medical, and financial records, along with other documentation, for a period of not less than five years from the date of payment, except rural health clinic providers who are required to retain records for a minimum of six years from the date of payment
- Billing only for services that were actually provided
- Allowing a member access to their records
- Monitoring contracted staff
- Accepting Medicaid reimbursement as payment in full for covered services
- Keeping provider information (for example, address, business name) current
- Notifying ForwardHealth of changes in ownership
- Responding to Medicaid revalidation notifications
- Safeguarding member confidentiality
- Verifying member enrollment
- Keeping up-to-date with changes in program requirements as announced in ForwardHealth publications

Topic #217

Keeping Information Current

Changes That Require ForwardHealth Notification

Providers are required to notify ForwardHealth of any changes to their demographic information, including the following, as they occur:

- Address(es) — practice location and related information, mailing, PA (prior authorization), and/or financial

  Note: Health care providers who are federally required to have an NPI (National Provider Identifier) are cautioned that changes to their practice location address on file with ForwardHealth may alter their ZIP+4 code information that is required on transactions.

- Business name
- Contact name
- Federal Tax ID number (IRS (Internal Revenue Service) number)
- Group affiliation
- Licensure
- NPI
- Ownership
- Professional certification
- Provider specialty
- Supervisor of nonbilling providers
- Taxonomy code
- Telephone number, including area code

Failure to notify ForwardHealth of changes may result in the following:

- Incorrect reimbursement

- Misdirected payment
- Claim denial
- Suspension of payments or cancellation of provider file if provider mail is returned to ForwardHealth for lack of a current address

Entering new information on a claim form or PA request is **not** adequate notification of change.

Notifying ForwardHealth of Changes

Providers can notify ForwardHealth of changes using the demographic maintenance tool.

Providers Enrolled in Multiple Programs

If demographic information changes, providers enrolled in multiple programs (for example, Wisconsin Medicaid and WCDP (Wisconsin Chronic Disease Program)) will need to change the demographic information for each program. By toggling between accounts using the Switch Organization function of the Portal, providers who have a Portal account for each program can change their information for each program using the demographic maintenance tool. The Account User Guide provides specific information about switching organizations.

Providers Licensed or Certified by the Division of Quality Assurance

Providers licensed or certified by the DQA (Division of Quality Assurance) are required to notify the DQA of changes to physical address, changes of ownership, and facility closures by emailing Lisa.Imhof@dhs.wisconsin.gov.

Topic #577

Legal Framework

The following laws and regulations provide the legal framework for BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid:

- Federal Law and Regulation:
  - Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI
  - Regulation — Title 42 C.F.R. Parts 430-498 and Parts 1000-1008 (Public Health)
- Wisconsin Law and Regulation:
  - Law — Wis. Stat. §§ 49.43–49.499, 49.665, and 49.473
  - Regulation — Wis. Admin. Code chs. DHS 101, 102, 103, 104, 105, 106, 107, and 108

Laws and regulations may be amended or added at any time. Program requirements may not be construed to supersede the provisions of these laws and regulations.

The information included in the ForwardHealth Portal applies to BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid. BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid are administered by Wisconsin DHS (Department of Health Services). Within DHS, DMS (Division of Medicaid Services) is directly responsible for managing these programs.

Topic #17097

Licensure Information

Licensed providers are required to keep all licensure information, including license number, grant and expiration dates, and

physical location as applicable (for example, hospital providers), current with ForwardHealth.

If providers do not keep their licensure information, including their license number, current with ForwardHealth, any of the following may occur:

- Providers' enrollment may be deactivated. As a result, providers would not be able to submit claims or PA (prior authorization) requests or be able to function as prescribing/referring/ordering providers, if applicable, until they update their licensure information.
- Providers may experience a lapse in enrollment. If a lapse occurs, providers may need to re-enroll, which may result in another application fee being assessed.

Providers may change the grant and expiration dates for their current license(s) and enter information for a new license(s), such as the license number, licensing state, and grant and expiration dates, using the demographic maintenance tool. After entering information for their new license(s), some providers (for example, out-of-state providers) will also be required to upload a copy of their license using the demographic maintenance tool. Provided licensure information must correspond with the information on file with the applicable licensing authority.

In some cases, ForwardHealth will need to verify licensure information with the applicable licensing authority, which may take up to 10 business days after submission. Providers updating their license information should plan accordingly so that they do not experience any of the indicated interruptions in enrollment. If provided licensure information (for example, grant and expiration dates) does not correspond with the licensing authority's information, the licensing authority's information will be retained and will display in the demographic maintenance tool once verified by ForwardHealth.

Topic #23639

Providers Administering IV Ketamine Infusion Therapy

Allowable prescribers for IV ketamine infusion therapy must be Medicaid-enrolled providers operating within their scope of practice. Prescribers also must follow all other applicable state and federal practice requirements, such as a DEA (Drug Enforcement Agency) registration to prescribe controlled substances.

IV ketamine infusion therapy must be administered:

- To a member in a medical office or medical facility such as an inpatient hospital, stand-alone outpatient clinic, or outpatient hospital clinic.
- By a physician or a qualified medical professional within their scope of practice.

Billing and Rendering Providers

To bill or render IV ketamine services, providers must enroll with Wisconsin Medicaid.

A provider who is not restricted to rendering only can enroll with Wisconsin Medicaid as both a billing and rendering provider.

Rendering-Only Providers

Providers who practice under the professional supervision of another provider (for example, nurse practitioners) must enroll with Wisconsin Medicaid as a rendering-only provider.

Providers enrolled as rendering providers cannot submit claims to ForwardHealth directly. Instead, they have reimbursement rates established for their provider type. Claims for services provided by a rendering provider must:

- Identify the Medicaid-enrolled rendering-provider.

- Identify the Medicaid-enrolled supervising provider or group provider as the billing provider.

Note: An RN (registered nurse) is not a recognized provider type in Wisconsin Medicaid. Therefore, an RN cannot enroll as either a rendering or a billing provider. An RN administering IV ketamine, even under the supervision of a physician, is still not a rendering provider under Wisconsin Medicaid.

Topic #15157

Recovery Audit Contractor Audits

The ACA (Affordable Care Act) requires states to establish an RAC (Recovery Audit Contractor) program to enable the auditing of Medicaid claim payments to providers. In Wisconsin, the RAC will audit claim payments from Wisconsin Medicaid and BadgerCare Plus. The Wisconsin DHS (Department of Health Services) has awarded the contract to HMS (Health Management Systems, Inc.) as the RAC for the state of Wisconsin.

Note: The RAC will not audit claims submitted for Family Planning Only Services, SeniorCare, WCDP (Wisconsin Chronic Disease Program), the WWWP (Wisconsin Well Woman Program), and HDAP (Wisconsin HIV Drug Assistance Program).

The overall goal of the RAC program is to identify and decrease improper payments. The audits will ensure that payments are for services covered under the programs in which the member was enrolled and that the services were actually provided and properly billed and documented. The audits are being conducted under Generally Accepted Government Auditing Standards.

Providers will be selected for audits based on data analysis by the RAC and referrals by state agencies. The RAC will ensure that its audits neither duplicate state audits of the same providers nor interfere with potential law enforcement investigations.

Providers who receive a notification regarding an audit should follow the instructions as outlined in the notification within the requested time frames.

Affected Providers

Any provider may be audited, including, but not limited to, fee-for-service providers, institutional and non-institutional providers, as well as managed care entities.

Additional Information

Any questions regarding the RAC program should be directed to HMS at 855-699-6289. Refer to the RAC website for additional information regarding HMS RAC activities.

Topic #13277

Reporting Suspected Waste, Fraud, and Abuse

The Wisconsin DHS (Department of Health Services) OIG (Office of Inspector General) investigates fraud and abuses including the following:

- Billing Medicaid for services or equipment that were not provided
- Submitting false applications for a DHS-funded assistance program such as Medicaid, BadgerCare Plus, WIC (Special Supplemental Nutrition Program for Women, Infants, and Children), or FoodShare
- Trafficking FoodShare benefits
- Crime, misconduct, and/or mismanagement by a DHS employee, official, or contractor

Those who suspect fraudulent activity in Medicaid programs are required to notify the OIG if they have reason to believe that a person is misusing or abusing any DHS health care program or the ForwardHealth identification card.

Wisconsin Stat. § 49.49 defines actions that represent member misuse or abuse of benefits and the resulting sanctions that may be imposed. Providers are under no obligation to inform the member that they are misusing or abusing their benefits. A provider may not confiscate a ForwardHealth card from a member in question.

Reporting Suspected Fraud and Abuse

Those who suspect any form of fraud, waste, or abuse of a program by providers, trading partners, billing services, agencies, or recipients of any government assistance program are required to report it. Those reporting allegations of fraud and abuse may remain anonymous. However, not providing contact information may prevent OIG from fully investigating the complaint if questions arise during the review process.

If a provider suspects that someone is committing fraudulent activities or is misusing their ForwardHealth card, the provider is required to notify ForwardHealth by one of the following methods:

- Going to the OIG fraud and abuse reporting website
- Calling the DHS fraud and abuse hotline at 877-865-3432

The following information is helpful when reporting fraud and abuse:

- A description of the fraud, waste, and/or abuse, including the nature, scope, and timeframe of the activity in question (The description should include sufficient detail for the complaint to be evaluated.)
- The names and dates of birth (or approximate ages) of the people involved, as well as the number of occurrences and length of the suspected activity
- The names and date(s) of other people or agencies to which the activity may have been reported

After the allegation is received, DHS OIG will evaluate it and take appropriate action. If the name and contact information of the person reporting the allegation was provided, the OIG may be in contact to verify details or ask for additional information.

Prescription

Topic #520

Disposable Medical Supplies and Durable Medical Equipment

All DME (durable medical equipment) and DMS (disposable medical supplies) require a prescription signed and dated by the prescriber except for the following DMS:

- Hearing instrument accessories
- Hearing instrument batteries
- Hearing instrument repairs

Prescribers are reminded that they are required to determine that all DME and DMS items are medically necessary before a prescription is written. More information about coverage and limitations is available under the DMS and DME service areas of this Online Handbook.

Breast Pumps

Wisconsin Medicaid reimburses for the prescribing of breast pumps as part of an E&M (evaluation and management) office visit. Providers are required to document clinical requirements of an individual's need for a breast pump.

Providers may prescribe breast pumps for members that can then be obtained through a Medicaid-enrolled DME vendor or pharmacy. Wisconsin Medicaid does not reimburse prescribing providers for supplying breast pumps, unless they are also Medicaid-enrolled as a DME vendor or a pharmacy.

Topic #525

General Requirements

It is vital that prescribers provide adequate supporting clinical documentation for a pharmacy or other dispensing providers to fill a prescription. Except as otherwise provided in federal or state law, a prescription must be in writing or given orally and later reduced to writing by the provider filling the prescription. The prescription must include the following information:

- The name, strength, and quantity of the drug or item prescribed
- The service required, if applicable
- The date of issue of the prescription
- The prescriber's name and address
- The member's name and address
- The prescriber's signature (if the prescriber writes the prescription) and date signed
- The directions for use of the prescribed drug, item, or service

Drug Enforcement Agency Number Audits

All prescriptions for controlled substances must indicate the DEA (Drug Enforcement Agency) number of the prescriber on all prescriptions. DEA numbers are not required on claims or PAs (prior authorizations).

Members in Hospitals and Nursing Homes

For hospital and nursing home members, prescriptions must be entered into the medical and nursing charts and must include the previously listed information. Prescription orders are valid for no more than one year from the date of the prescription except for controlled substances and prescriber-limited refills that are valid for shorter periods of time.

Topic #523

Prescriber Information for Drug Prescriptions

Most legend and certain OTC (over-the-counter) drugs are covered. (A legend drug is one whose outside package has the legend or phrase "Caution, federal law prohibits dispensing without a prescription" printed on it.)

Coverage for some drugs may be restricted by one of the following policies:

- PDL (Preferred Drug List)
- PA (prior authorization)
- BBG (brand before generic) drugs that require PA
- BMN (brand medically necessary) drugs that require PA
- Diagnosis-restricted drugs
- Age-restricted drugs
- Quantity limits

Prescribers are encouraged to write prescriptions for drugs that do not have restrictions; however, processes are available to obtain reimbursement for medically necessary drugs that do have restrictions.

For the most current prescription drug information, refer to the pharmacy data tables. Providers may also call Provider Services for more information.

Preferred Drug List

Most preferred drugs on the PDL do **not** require PA, although these drugs may have other restrictions (for example, age, diagnosis); non-preferred drugs **do** require PA. Prescribers are encouraged to write prescriptions for preferred drugs; however, a PA process is available for non-preferred drugs if the drugs are medically necessary.

Most drugs and drug classes included on the PDL are covered fee for service by BadgerCare Plus, Wisconsin Medicaid, and SeniorCare, but certain drugs may have restrictions (for example, diagnosis, quantity limits, age limits). Prescribers are encouraged to write prescriptions for preferred drugs if medically appropriate. Prescribers are encouraged to try more than one preferred drug, if medically appropriate for the member, before prescribing a non-preferred drug. Non-preferred drugs may be covered with an approved PA request. Most preferred drugs do not require PA, except in designated classes identified on the Preferred Drug List Quick Reference.

Prescriber Responsibilities for Non-Preferred Drugs

If a member is enrolled in BadgerCare Plus, Wisconsin Medicaid, or SeniorCare, prescribers are encouraged to write prescriptions for preferred drugs. Prescribers are encouraged to prescribe **more than one** preferred drug before a non-preferred drug is prescribed from the same drug class.

If a non-preferred drug or a preferred drug that requires clinical PA is medically necessary for a member, the prescriber must complete, sign, and date the appropriate PA form for the drug. When completing the PA form, prescribers are required to

provide a signature on the form.

The PA form must be sent to the pharmacy where the prescription will be filled. The PA form may be sent to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Prescribers and pharmacy providers are required to retain a completed, signed, and dated copy of the PA form.

PA for Weight Management Agents

Prescribers, or their designees, must request PA for weight management agents; pharmacy providers may not request PA for weight management agents.

Diagnosis-Restricted Drugs

Prescribers are required to indicate a diagnosis on prescriptions for all drugs that are identified by ForwardHealth as diagnosis-restricted.

Prescribing Drugs Manufactured by Companies Who Have Not Signed the Rebate Agreement

By federal law, pharmaceutical manufacturers who participate in state Medicaid programs must sign a rebate agreement with CMS (Centers for Medicare & Medicaid Services). BadgerCare Plus, Wisconsin Medicaid, and SeniorCare will cover legend and specific categories of OTC products of manufacturers who have signed a rebate agreement.

Note: SeniorCare does not cover OTC drugs, except insulin.

ForwardHealth has identified drug manufacturers who have signed the rebate agreement. By signing the rebate agreement, the manufacturer agrees to pay ForwardHealth a rebate equal to a percentage of its "sales" to ForwardHealth.

Drugs of companies choosing not to sign the rebate agreement, with few exceptions, are not covered. A Medicaid-enrolled pharmacy can confirm for prescribers whether or not a particular drug manufacturer has signed the agreement.

Members Enrolled in BadgerCare Plus, Wisconsin Medicaid, or SeniorCare (Levels 1 and 2A)

BadgerCare Plus, Medicaid, and SeniorCare levels 1 and 2A may cover certain FDA (Food and Drug Administration)-approved legend drugs through the PA process even though the drug manufacturers did not sign rebate agreements.

Prescribers are required to complete the appropriate section(s) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (01/2024)) as it pertains to the drug being requested.

Included with the PA request, the prescriber is required to submit documentation of medical necessity and cost-effectiveness that the non-rebated drug is the only available and medically appropriate product for treating the member. The documentation must include the following:

- A copy of the medical record or documentation of the medical history detailing the member's medical condition and previous treatment results
- Documentation by the prescriber that shows why other drug products have been ruled out as ineffective or unsafe for the member's medical condition
- Documentation by the prescriber that shows why the non-rebated drug is the most appropriate and cost-effective drug to

treat the member's medical condition

If a PA request for a drug without a signed manufacturer rebate is approved, claims for drugs without a signed rebate agreement must be submitted on paper. Providers should complete and submit the Noncompound Drug Claim (F-13072 (02/2025)) form indicating the actual NDC (National Drug Code) of the drug with the Pharmacy Special Handling Request (F-13074 (04/2014)) form.

If a PA request for a drug without a signed manufacturer rebate is denied, the service is considered noncovered.

Members Enrolled in SeniorCare (Levels 2B and 3)

PA is not available for drugs from manufacturers without a separate, signed SeniorCare rebate agreement for members in levels 2B and 3. PA requests submitted for drugs without a separate, signed SeniorCare rebate agreement for members in levels 2B and 3 will be returned to the providers unprocessed and the service will be noncovered. Members do not have appeal rights regarding returned PA requests for noncovered drugs.

Prospective Drug Utilization Review System

The federal OBRA (Omnibus Budget Reconciliation Act) of 1990 (42 C.F.R. Parts 456.703 and 456.705) called for a DUR (Drug Utilization Review) program for all Medicaid-covered drugs to improve the quality and cost-effectiveness of member care. ForwardHealth's prospective DUR system assists pharmacy providers in screening certain drug categories for clinically important potential drug therapy problems before the prescription is dispensed to the member. The prospective DUR system checks the member's entire pharmacy paid claims history regardless of where the drug was dispensed or by whom it was prescribed.

Diagnoses from medical claims are used to build a disease or pregnancy profile for each member. The prospective DUR system uses this profile to determine whether or not a prescribed drug may be inappropriate or harmful to the member. It is very important that prescribers provide up-to-date medical diagnosis information about members on medical claims to ensure complete and accurate member profiles, particularly in cases of disease or pregnancy.

Note: The prospective DUR system does not dictate which drugs may be dispensed; prescribers and pharmacists must exercise professional judgment.

Prospective Drug Utilization Review's Impact on Prescribers

If a pharmacy receives a prospective DUR alert, a DUR segment is required before the drug can be dispensed to the member. This may require the pharmacist to contact the prescriber for additional information to determine if the prescription should be filled as written, modified, or cancelled.

Drugs With Three-Month Supply Requirement

ForwardHealth has identified a list of three-month supply drugs:

- Certain drugs are required to be dispensed in a three-month supply.
- Additional drugs are allowed to be dispensed in a three-month supply.

Member Benefits

When it is appropriate for the member's medical condition, a three-month supply of a drug benefits the member in the following ways:

- Aiding compliance in taking prescribed generic, maintenance medications
- Reducing the cost of member copays

- Requiring fewer trips to the pharmacy
- Allowing the member to obtain a larger quantity of generic, maintenance drugs for chronic conditions (for example, hypertension)

Prescribers are encouraged to write prescriptions for a three-month supply when appropriate for the member.

Prescription Quantity

A prescriber is required to indicate the appropriate quantity on the prescription to allow the dispensing provider to dispense the maintenance drug in a three-month supply. For example, if the prescription is written for "Hydrochlorothiazide 25 mg, take one tablet daily," the prescriber is required to indicate a quantity of 90 or 100 tablets on the prescription so the pharmacy provider can dispense a three-month supply. In certain instances, brand name drugs (for example, oral contraceptives) may be dispensed in a three-month supply.

Pharmacy providers are not required to contact prescribers to request a new prescription for a three-month supply if a prescription has been written as a one-month supply with multiple or as needed (PRN (pro re nata)) refills.

ForwardHealth will not audit or recoup three-month supply claims if a pharmacy provider changes a prescription written as a one-month supply with refills as long as the total quantity dispensed per prescription does not exceed the total quantity authorized by the prescriber.

Prescription Mail Delivery

Current Wisconsin law permits Medicaid-enrolled retail pharmacies to deliver prescriptions to members via the mail. Medicaid-enrolled retail pharmacies may dispense and mail any prescription or OTC medication to a Medicaid fee-for-service member at no additional cost to the member or Wisconsin Medicaid.

Providers are encouraged to use the mail delivery option if requested by the member, particularly for prescriptions filled for a three-month supply.

Noncovered Drugs

The following drugs are not covered:

- Drugs that are identified by the FDA as LTE (less-than-effective) or identical, related, or similar to LTE drugs
- Drugs identified on the Wisconsin Negative Formulary
- Drugs manufactured by companies that have not signed the rebate agreement
- Drugs to treat the condition of ED (erectile dysfunction). Examples of noncovered drugs for ED are tadalafil (Cialis) and sildenafil (Viagra).

SeniorCare

SeniorCare is a prescription drug assistance program for Wisconsin residents who are 65 years of age or older and meet eligibility criteria. SeniorCare is modeled after Wisconsin Medicaid in terms of drug coverage and reimbursement, although there are a few differences. Unlike Wisconsin Medicaid, SeniorCare does not cover OTC drugs other than insulin. SeniorCare also covers vaccines that are approved by the CDC (Centers for Disease Control and Prevention) ACIP (Advisory Committee on Immunization Practices) for people age 65 and older and are administered through a pharmacy.

Topic #4346

Tamper-Resistant Prescription Pad Requirement

Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 imposed a requirement on prescriptions paid for by Medicaid, SeniorCare, or BadgerCare fee-for-service. The law requires that all written or computer-generated prescriptions that are given to a patient to take to a pharmacy must be written or printed on tamper-resistant prescription pads or tamper-resistant computer paper. This requirement applies to prescriptions for both controlled and noncontrolled substances.

All other Medicaid policies and procedures regarding prescriptions continue to apply.

Required Features for Tamper-Resistant Prescription Pads or Computer Paper

To be considered tamper-resistant, federal law requires that prescription pads/paper contain all three of the following characteristics:

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms

Exclusions to Tamper-Resistant Prescription Pad Requirement

The following are exclusions to the tamper-resistant prescription pad requirement:

- Prescriptions faxed directly from the prescriber to the pharmacy
- Prescriptions electronically transmitted directly from the prescriber to the pharmacy
- Prescriptions telephoned directly from the prescriber to the pharmacy
- Prescriptions provided to members in nursing facilities, ICF/IIDs (Intermediate Care Facilities for Individuals with Intellectual Disabilities), and other specified institutional and clinical settings to the extent that drugs are part of their overall rate (However, written prescriptions filled by a pharmacy outside the walls of the facility are subject to the tamper-resistant requirement.)

72-Hour Grace Period

Prescriptions presented by patients on non-tamper-resistant pads or paper may be dispensed and considered compliant if the pharmacy receives a compliant prescription order within 72 hours.

Coordination of Benefits

The federal law imposing these new requirements applies even when ForwardHealth is the secondary payer.

Retroactive ForwardHealth Eligibility

If a patient becomes retroactively eligible for ForwardHealth, the federal law presumes that prescriptions retroactively dispensed were compliant. However, prospective refills will require a tamper-resistant prescription.

Penalty for Noncompliance

Payment made to the pharmacy for a claim corresponding to a noncompliant order may be recouped, in full, by Wisconsin

Medicaid.

Provider Enrollment

Topic #15497

Advanced Practice Nurse Prescribers

APNPs (Advanced Practice Nurse Prescribers) with a psychiatric specialty and psychiatrists are the only mental health providers who can submit claims for psychotherapy services that include a medical E&M (evaluation and management) component. Additionally, APNPs with a psychiatric specialty are required to be separately enrolled in Medicaid as a nurse practitioner in order to be reimbursed for an E&M service.

Topic #1035

Age-Specific Requirements for Providing Ventilator-Dependent Services

Nurses providing PDN (private duty nursing) services to ventilator-dependent members are required to submit documentation of Medicaid-approved recognition of age-specific skills acquisition demonstrations for the pediatric and/or adult members they serve. Wisconsin Medicaid pediatric PDN enrollment applies to children ages 0–16. Wisconsin Medicaid adult PDN enrollment applies to adults ages 17 and older.

Child to Adult Transition Period Requirements

A transitional ventilator-dependent recipient is a member who is between the ages of 16 and 18.

A nurse who is certified to provide services to ventilator-dependent pediatric members (but not adult members) may continue to submit claims for services to a member for whom authorization has been granted prior to the member aging into the transition period. The nurse may continue to serve the member when the member turns 17 and until whichever of the following situations occurs first:

- The date the nurse is required to renew their pediatric skills demonstration
- The member's 19th birthday

At that time, the nurse is required to meet the Wisconsin Medicaid adult certification requirement to continue providing services to the member.

A nurse certified only for pediatric care may not provide PDN to any adult ventilator-dependent member over the age of 17 unless the nurse began providing uninterrupted service to the member before the member's 17th birthday.

Topic #899

CLIA Certification or Waiver

Congress implemented CLIA (Clinical Laboratory Improvement Amendment) to improve the quality and safety of laboratory services. CLIA requires **all** laboratories and providers that perform tests (including waived tests) for health assessment or for the diagnosis, prevention, or treatment of disease or health impairment to comply with specific federal quality standards. This

requirement applies even if only a single test is being performed.

CLIA Enrollment

The federal CMS (Centers for Medicare and Medicaid Services) sends CLIA enrollment information to ForwardHealth. The enrollment information includes CLIA identification numbers for all current laboratory sites. ForwardHealth verifies that laboratories are CLIA certified before Medicaid grants enrollment.

CLIA Regulations

ForwardHealth complies with the following federal regulations as initially published and subsequently updated:

- Public Health Service Clinical Laboratory Improvement Amendments of 1988
- Title 42 C.F.R. Part 493, Laboratory Requirements

Scope of CLIA

CLIA governs all laboratory operations, including:

- Accreditation
- Certification
- Fees
- Patient test management
- Personnel qualifications
- Proficiency testing
- Quality assurance
- Quality control
- Records and information systems
- Sanctions
- Test methods, equipment, instrumentation, reagents, materials, supplies
- Tests performed

CLIA regulations apply to **all** providers who perform CLIA-monitored laboratory services, including:

- Clinics
- HealthCheck providers
- Independent clinical laboratories
- Nurse midwives
- Nurse practitioners
- Osteopaths
- Pharmacists
- Physician assistants
- Physicians
- Rural health clinics

CLIA Certification Types

CMS regulations require providers to have a CLIA certificate that indicates the laboratory is qualified to perform a category of tests.

Clinics or groups with a single group billing certification, but multiple CLIA numbers for different laboratories, may wish to contact

Provider Services to discuss various certification options. There are five types of CLIA certificates as defined by CMS:

1. **Certificate of Waiver**. This certificate is issued to a laboratory to perform only waived tests. The CMS website identifies the most current list of waived procedures. BadgerCare Plus identifies allowable waived procedures in maximum allowable fee schedules.
2. **Certificate for Provider-Performed Microscopy Procedures (PPMP)**. This certificate is issued to a laboratory in which a physician, mid-level practitioner, or dentist performs no tests other than the microscopy procedures. This certificate permits the laboratory to also perform waived tests. The CMS website identifies the most current list of CLIA-allowable provider-performed microscopy procedures. BadgerCare Plus identifies allowable provider-performed microscopy procedures in fee schedules.
3. **Certificate of Registration**. This certificate enables a laboratory to conduct moderate- or high-complexity laboratory testing, or both, until the lab is determined by survey to be in compliance with CLIA regulations.
4. **Certificate of Compliance**. This certificate is issued to a laboratory after an inspection that finds the laboratory to be in compliance with all applicable CLIA requirements.
5. **Certificate of Accreditation**. This certificate is issued to a laboratory on the basis of the laboratory's accreditation by an organization approved by CMS. The six major approved accreditation organizations are:
    - The Joint Commission
    - CAP (College of American Pathologists)
    - COLA (Commission on Laboratory Accreditation)
    - American Osteopathic Association
    - American Association of Blood Banks
    - ASHI (American Society of Histocompatibility and Immunogenetics)

Applying for CLIA Certification

Use the CMS 116 CLIA application to apply for program certificates. Providers can get CMS 116 forms from the CMS website or from Wisconsin DHS (Department of Health Services) at:

Division of Quality Assurance
Clinical Laboratory Section
201 E Washington Ave
PO Box 2969
Madison WI 53701-2969

Providers Required to Report Changes

Providers are required to notify Provider Enrollment within 30 days of any changes in ownership, name, location, or director. Providers are also required to notify Provider Enrollment of changes in CLIA certificate types immediately and within six months when a specialty or subspecialty is added or deleted.

Providers may notify Provider Enrollment of changes by uploading supporting documentation using the demographic maintenance tool or by mailing supporting documentation to:

Wisconsin Medicaid
Provider Enrollment
313 Blettner Blvd
Madison WI 53784

If a provider has a new certificate type to add to the certification information on file with ForwardHealth, the provider should upload or mail a copy of the new certificate. When a provider sends ForwardHealth a copy of a new CLIA certificate, the effective date on the certificate will become the effective date for CLIA certification on file with ForwardHealth.

Topic #3969

Categories of Enrollment

Wisconsin Medicaid enrolls providers in three billing categories. Each billing category has specific designated uses and restrictions. These categories include:

- Billing and rendering provider
- Rendering-only provider
- Billing-only provider (including group billing)

Providers should refer to the service-specific information in the Online Handbook or the Information for Specific Provider Types page on the Provider Enrollment Information home page to identify which category of enrollment is applicable.

Billing and Rendering Provider

Enrollment as a billing and rendering provider allows providers to identify themselves on claims (and other forms) as either the provider billing for the services or the provider rendering the services.

Rendering-Only Provider

A provider enrolled as a rendering-only provider who practices under the professional supervision of another provider. Rendering-only providers enrollment cannot submit claims to ForwardHealth directly. Instead, they have reimbursement rates established for their provider type. Claims for services provided by a rendering provider must include the supervising provider or group provider as the billing provider.

Billing-Only Provider (Including Group Billing)

Billing-only providers can submit claims to ForwardHealth while a separate rendering-only provider is required on those claims.

Group Billing

Groups of individual practitioners are enrolled as billing-only providers as an accounting convenience. This allows the group to receive one reimbursement, one RA (Remittance Advice), and the 835 (835 Health Care Claim Payment/Advice) transaction for covered services rendered by individual practitioners within the group.

Providers may not have more than one group practice enrolled in Wisconsin Medicaid with the same ZIP+4 code address, NPI (National Provider Identifier), and taxonomy code combination. Provider group practices located at the same ZIP+4 code address are required to differentiate their enrollment using an NPI or taxonomy code that uniquely identifies each group practice.

Individual practitioners within group practices are required to be Medicaid-enrolled because these groups are required to identify the provider who rendered the service on claims. Claims indicating these group billing providers that are submitted without a rendering provider are denied.

Topic #1002

Durable Medical Equipment

To be reimbursed for dispensing DME (durable medical equipment), prescribers are required to obtain separate Medicaid enrollment as a Medical Supply and Equipment Vendor. Prescribers are required to comply with all federal laws and regulations,

including the Stark statute on referrals.

Topic #14137

Enrollment Requirements Due to the Affordable Care Act

In 2010, the federal government signed into law the ACA (Affordable Care Act), also known as federal health care reform, which affects several aspects of Wisconsin health care. ForwardHealth worked toward ACA compliance by implementing requirements for providers and provider screening processes. To meet federally mandated requirements, ForwardHealth implemented changes in phases, the first of which began in 2012. A high-level list of the changes included under ACA is as follows:

- Providers are assigned a risk level of limited, moderate, or high. Most of the risk levels have been established by the federal CMS (Centers for Medicare & Medicaid Services) based on an assessment of potential fraud, waste, and abuse for each provider type.
- Providers are screened according to their assigned risk level. Screenings are conducted during enrollment, re-enrollment, and revalidation.
- Certain provider types are subject to an application fee. This fee has been federally mandated and may be adjusted annually. The fee is used to offset the cost of conducting screening activities.
- Providers are required to undergo revalidation every three years.
- All physicians and other professionals who prescribe, refer, or order services and other providers who receive Medicaid funds are required to be enrolled as a participating Medicaid provider.
- Payment suspensions are imposed on providers based on a credible allegation of fraud.
- Providers are required to submit personal information about all persons with an ownership or controlling interest, agents, and managing employees at the time of enrollment, re-enrollment, and revalidation.

Topic #1037

Enrollment and Training Requirements for Nurses Providing Ventilator-Dependent Services

Nurses who are already enrolled as individual NIP (nurses in independent practice) but want to provide PDN (private duty nursing) services to ventilator-dependent members are required to attest that they will meet and follow the enrollment regulations under Wis. Admin. Code § DHS 105.19 using the demographic maintenance tool. Additionally, nurses are required to complete an age-specific respiratory skills acquisition demonstration and report information regarding the demonstration using the demographic maintenance tool.

Note: If nurses allow their certification to provide PDN services to ventilator-dependent members to lapse, they will no longer be enrolled to provide PDN to ventilator-dependent members.

To be reimbursed by Wisconsin Medicaid for PDN services provided to ventilator-dependent members, nurses are required to do the following:

- Become enrolled in Wisconsin Medicaid as an NIP or nurse practitioner.
- Complete an age-specific respiratory skills acquisition demonstration as required by ForwardHealth and indicate the following to ForwardHealth using the demographic maintenance tool:
  - Whether or not they have been recognized by an approved facility in the last two years as having successfully demonstrated the respiratory care skills required by ForwardHealth. A link to these requirements can be found on the applicable respiratory care panel in the demographic maintenance tool.

- Date the respiratory skills acquisition demonstration (declaration of skill acquisition) was completed.
- Information about where CPR training was received, including the facility's address and the instructor's name.
- Whether or not they have a CPR card from an approved facility that documents that they successfully completed a CPR course for the professional rescuer within the last two years.
- CPR card information, including the candidate's name, the issue date, and the renewal/expiration date.

- Submit the following to ForwardHealth upon completion of the respiratory skills acquisition demonstration and before the renewal deadline:
  - Current documentation of their respiratory skills recognition certificate from a hospital accredited by The Joint Commission or proof of age-appropriate respiratory skills acquisition from a nursing home that is state approved for ventilator care.
  - A copy of their valid CPR card (Basic Life Support for Health Care Providers Program from the American Red Cross or American Heart Association).

  Providers may submit renewal and training documentation by uploading it through the demographic maintenance tool or mailing it to the following address:

  Wisconsin Medicaid
  Provider Enrollment
  313 Blettner Blvd
  Madison WI 53784

Upon submission of any of the above information, a message will display in the demographic maintenance tool indicating that the providers' information was uploaded successfully. Additionally, an Application Submitted panel will display and indicate next steps. ForwardHealth will verify changes to the information within 10 business days of submission.

If the changes can be verified, ForwardHealth will update providers' files. ForwardHealth will not notify nurse practitioners and NIP that their provider files have been updated. The changed information is not considered approved until 10 business days after the information was changed.

If the changes cannot be verified within 10 business days, ForwardHealth will notify nurse practitioners and NIP by mail that their provider files were not updated. Nurse practitioners and NIP will need to make corrections using the demographic maintenance tool.

Demonstration Renewals

Nurses are required to renew their respiratory skills acquisition demonstration within 24 months of the date of their last demonstration, or they will no longer be enrolled to provide private duty nursing to ventilator-dependent members.

It is the nurse's responsibility to repeat the respiratory skills acquisition demonstration and submit the required information and upload the certificate to ForwardHealth by the renewal deadline.

Topic #999

Express Enrollment for Pregnant Women Benefit

Physicians, physician assistants, nurse practitioners, and nurse midwives may become Medicaid-enrolled EE (express enrollment) providers. EE for Pregnant Women Benefit providers determine whether a pregnant woman may be eligible for BadgerCare Plus. The EE for Pregnant Women Benefit is a limited benefit category that allows an uninsured or underinsured (for example, insured without prenatal coverage) pregnant woman to receive immediate pregnancy-related outpatient services while their application for full-benefit BadgerCare Plus is processed.

Topic #194

In-State Emergency Providers and Out-of-State Providers

ForwardHealth requires all in-state emergency providers and out-of-state providers who render services to BadgerCare Plus, Medicaid, or SeniorCare members to be enrolled in Wisconsin Medicaid. Information is available regarding the enrollment options for in-state emergency providers and out-of-state providers.

In-state emergency providers and out-of-state providers who dispense covered outpatient drugs will be assigned a professional dispensing fee reimbursement rate of $10.51.

Topic #193

Materials for New Providers

On an ongoing basis, providers should refer to the Online Handbook for the most current BadgerCare Plus, Medicaid, and HDAP (Wisconsin HIV Drug Assistance Program) information. Future changes to policies and procedures are published in ForwardHealth Updates.

Topic #865

Nurse Practitioners

Nurse practitioners who treat ForwardHealth members are required to be Medicaid-enrolled to receive reimbursement. This applies to nurse practitioners whose services are reimbursed under a physician's or clinic's NPI (National Provider Identifier), as well as to those who independently submit claims to ForwardHealth.

Medicaid services performed by nurse practitioners must be within the legal scope of practice as defined under the Wisconsin Board of Nursing licensure or certification. Services performed must be included in the individual nurse practitioner's protocols or a collaborative relationship with a physician as defined by the Board of Nursing.

Most advanced practice nurse prescribers who apply for Medicaid enrollment are enrolled as nurse practitioners (except for non-Master's degree-prepared nurse midwives and certified registered nurse anesthetists).

Pursuant to Board of Nursing Wis. Admin. Code § N 8.10(7), 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 ForwardHealth pharmacy publications. Providers may also call Provider Services for more information.

Medicaid-enrolled nurse practitioners who provide delegated medical care under the general supervision of a physician are required to be supervised only to the extent required pursuant to Board of Nursing Wis. Admin. Code § N 6.02(7). (Chapter N 6 defines general supervision as the regular coordination, direction, and inspection of the practice of another and does **not** require the physician to be on site.)

Note: Medicaid enrollment is not required for nurse practitioners working in family planning clinics or as psychiatric nurse practitioners/clinical nurse specialists. Family planning clinics and psychiatric nurse practitioners/clinical nurse specialists should

refer to their service-specific areas of this Web site for information on covered services and related limitations.

Services provided by registered nurses who do not meet Medicaid nurse practitioner enrollment requirements may be reimbursed as services provided by ancillary providers.

Protocols/Collaborative Agreements

Pursuant to Wis. Admin. Code § N 8.10(7), 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 Wis. Admin. Code § N 6.03(2), nurse practitioners may only perform those delegated medical acts for which there are protocols or written or verbal orders, and which the nurse practitioner is competent to perform based on his or her nursing education, training, or experience. Nurse practitioners may perform delegated medical acts under the general supervision or direction of a physician, podiatrist, dentist, or optometrist. In addition, nurse practitioners are required to consult with a physician, podiatrist, dentist, or optometrist in cases where the nurse practitioner knows or should know a delegated medical act may harm a patient.

For purposes of Medicaid enrollment, **no** service which is a medical act and is listed as an allowable physician service may be performed without a collaborative practice agreement as required for advanced practice nurse prescribers, pursuant to Wis. Admin. Code § N 8.10(7), or protocols, and written or verbal orders for other Medicaid-enrolled nurse practitioners pursuant to Wis. Admin. Code § N 6.03(1).

Topic #23317

Pharmacists

Pharmacists are required to be Medicaid-enrolled for reimbursement of covered medical services provided to Medicaid or BadgerCare Plus members.

2021 Wisconsin Act 98 grants the DHS (Department of Health Services) authority to reimburse licensed pharmacists for services delegated to them by a physician through a CPA (collaborative practice agreement) or for services that are within the pharmacist's scope of practice.

Providers are required to attest to whether they have any CPAs in place during the enrollment process.

Collaborative Practice Agreement Policy

A CPA is a formal agreement between a physician (as described in Wis. Stat. § 448.01[5])and a pharmacist. A physician delegates to a pharmacist the authority to provide services that would typically be provided by the physician. Delegated services may be for select patients or a select group or groups of patients (such as all patients who have high blood pressure). The physician is ultimately responsible for the services the pharmacist provides to the physician's patients.

The services delegated and overall composition of CPAs may vary. Because of the variation, the CPA policy is broken into two parts, required and recommended, with an overarching policy that both the physician and the pharmacist must be enrolled in Wisconsin Medicaid. The CPA is required to be on file with the providers and must be made available at the request of DHS.

Pharmacists are required to update their demographic maintenance information with any changes related to CPA status. Details about updating information using the demographic maintenance tool are available in the ForwardHealth Portal Demographic Maintenance Tool User Guide.

Requirements

The CPA must include the following:

- One of the following for enrolled physicians:
  - The name and license number of any delegating physicians.
  - The written protocol that identifies the organization's medical committee delegating the authority and is approved by the organization's physician staff.

- One of the following for enrolled pharmacists:
  - The name and license number of any pharmacist who may perform the delegated acts.
  - The written protocol from the delegating authority that identifies the authority delegated to the organization's pharmacist or pharmacists.

- The patient or groups of patients eligible to receive delegated services under the agreement, including any patient inclusion or exclusion criteria.
- The delegated services that the pharmacist may perform.
- The process for the physician or designee of the physician to monitor compliance with the delegation agreement by the pharmacist.
- The process for how the delegated services provided by the pharmacist will be documented or included in the patient's health record.

The physician(s) and pharmacist(s) are required to review the CPA, and it must be renewed no later than every three years for the pharmacist(s) to continue providing delegated services. Payments for services provided by a pharmacist without a current CPA may be recouped.

Additional Recommendations

In addition, the CPA may include any of the following:

- A process for reviewing, revising, or renewing the CPA
- A method for terminating the CPA
- Guidelines for referring the patient back to the physician
- A process for the physician to provide feedback and quality assurance to the pharmacist
- Guidelines for communication and documentation between the pharmacist and the physician
- Guidelines for documentation retention of services provided by the pharmacist
- A description for additional training the physician is requiring of the pharmacist

Pharmacists who receive Medicaid reimbursement for delegated services:

- May be subject to audit at any time.
- Are required to retain relevant documentation supporting adherence to program requirements and produce it for and/or submit it to ForwardHealth upon request.

ForwardHealth may deny or recoup payment for services that fail to meet program requirements.

Topic #23797

Physician Assistants

A physician assistant may provide the same types of services that a physician would provide, such as diagnostic, palliative, preventative, rehabilitative, and therapeutic practices, such as:

- Conducting examinations.
- Offering treatment.
- Prescribing, ordering, procuring, dispensing, and administering medications, medical devices, services, and supplies.
- Performing surgery.
- Providing medical advice.
- Serving as primary care and specialty care providers.
- Delegating a care task to another clinically trained health care worker.

The physician is not required to be present when the physician assistant renders a service.

Physician assistants must practice within their legal scope of practice under Wis. Stat. § 448.975 and are required to maintain current information about themselves on the Portal using the demographic maintenance tool. Physician assistants should make sure their information is up to date before submitting claims to ForwardHealth.

Practice Policy

In compliance with 2021 Wisconsin Act 23 and the Physician Assistant Affiliated Credentialing Board, ForwardHealth requires physician assistants to maintain either:

- Evidence there is a physician who is primarily responsible for the overall direction and management of the physician assistant's professional activities and who assures that the services provided by the physician assistant are medically appropriate as outlined in 2021 Wisconsin Act 23 and Chapter PA 3.
- A collaborative practice agreement with a physician that describes the physician assistant's individual scope of practice.

Collaborative Practice Agreement

A collaborative practice agreement policy is a formal agreement created by and between a physician and a physician assistant that is submitted to the Physician Assistant Affiliated Credentialing Board upon request.

ForwardHealth may recoup payment for services provided by a physician assistant without a current collaborative practice agreement or a comparable agreement that meets program requirements.

The collaborative practice agreement must include:

- The name and license number of the physician entering the agreement.
- The name and license number of the physician assistant entering the agreement.
- A description of the physician assistant's individual scope of practice.
- A clause that specifies:
  - The collaborating physician shall remain reasonably available to the physician assistant using telecommunications or other electronic means within a medically appropriate time frame.
  - The collaborating physician may designate an alternative collaborator when unavailable.
- A protocol for identifying an alternative collaborating physician for when the collaborating physician or the physician's designee is not available for consultation.
- An arrangement for physician consultation with the patient within a medically appropriate time frame for consultation, if requested by the physician assistant's patient.
- The specific time limit of the agreement.
- The signature and date of the physician entering into the agreement.
- The signature and date of the physician assistant entering into the agreement.
- Other requirements required by the physician assistant credentialling board.

Note: Either the physician or physician assistant may terminate the agreement by providing written notice 30 days in advance.

Collaborative Practice Agreements Requirements

ForwardHealth requires the physician(s) and physician assistant(s) listed on a collaborative practice agreement to review the agreement every three years. The physician(s) and physician assistant(s) listed in the agreement must maintain current Medicaid enrollment status for the agreement to remain valid. To maintain enrollment, providers must go through Medicaid Provider revalidation, which occurs every three years.

Physician assistants who receive Medicaid reimbursement:

- May be audited at any time.
- Must retain relevant documentation supporting adherence to program requirements and submit it to ForwardHealth upon request.

Topic #4457

Provider Addresses

ForwardHealth has the capability to store the following types of addresses and contact information:

- **Practice location address and related information.** This address is where the provider's office is physically located and where records are normally kept. Additional information for the practice location includes the provider's office telephone number and the telephone number for members' use. With limited exceptions, the practice location and telephone number for members' use are published in a provider directory made available to the public.
- **Mailing address.** This address is where ForwardHealth will mail general information and correspondence. Providers should indicate accurate address information to aid in proper mail delivery.
- **PA (prior authorization) address.** This address is where ForwardHealth will mail PA information.
- **Financial addresses.** Two separate financial addresses are stored for ForwardHealth. The checks address is where ForwardHealth will mail paper checks. The 1099 mailing address is where ForwardHealth will mail IRS Form 1099.

Providers may submit additional address information or modify their current information using the demographic maintenance tool.

Note: Providers are cautioned that any changes to their practice location on file with Wisconsin Medicaid may alter their ZIP+4 code information required on transactions. Providers may verify the ZIP+4 code for their address on the U.S. Postal Service website.

Topic #14157

Provider Enrollment Information Home Page

ForwardHealth has consolidated all information providers will need for the enrollment process in one location on the ForwardHealth Portal. For information related to enrollment criteria and to complete online provider enrollment applications, providers should refer to the Provider Enrollment Information home page.

The Provider Enrollment Information home page includes enrollment applications for each provider type and specialty eligible for enrollment with Wisconsin Medicaid. Prior to enrolling, providers may consult a provider enrollment criteria menu, which is a reference for each individual provider type detailing the information the provider may need to gather before beginning the enrollment process, including:

- Links to enrollment criteria for each provider type
- Provider terms of reimbursement
- Disclosure information

- Category of enrollment
- Additional documents needed (when applicable)

Providers will also have access to a list of links related to the enrollment process, including:

- General enrollment information
- Regulations and forms
- Provider type-specific enrollment information
- In-state and out-of-state emergency enrollment information
- Contact information

Information regarding enrollment policy and billing instructions may still be found in the Online Handbook.

Topic #1931

Provider Type and Specialty Changes

Provider Type

Providers who want to add a provider type or change their current provider type are required to complete a new enrollment application for each provider type they want to add or change to because they need to meet the enrollment criteria for each provider type.

Provider Specialty

Providers who have the option to add or change a provider specialty can do so using the demographic maintenance tool. After adding or changing a specialty, providers may be required to submit documentation to ForwardHealth, either by uploading through the demographic maintenance tool or by mail, supporting the addition or change.

Providers should contact Provider Services with any questions about adding or changing a specialty.

Topic #22257

Providers Have 35 Days to Report a Change in Ownership

Medicaid-enrolled providers must notify ForwardHealth of a change in ownership within 35 calendar days after the effective date of the change per CMS (Centers for Medicare & Medicaid Services) Final Rule 42 C.F.R. § 455.104(c)(1)(iv).

Failure to report a change in ownership within 35 calendar days may result in denial of payment per 42 C.F.R. § 455.104.

Note: For demographic changes that do not constitute a change in ownership, providers should update their current information using the demographic maintenance tool.

New Enrollment Application Is Required

Any time a change in ownership occurs, providers must complete a new Medicaid provider enrollment application on the Portal. Indicate that this is a change of ownership on the application.

ForwardHealth must receive the change in ownership application, which must include the affected provider number (NPI (National Provider Identifier) or provider ID), **within 35 calendar days after the effective date of the change in ownership**.

Providers will receive written notification of their new Medicaid enrollment effective date in the mail once their provider file is updated with the change in ownership.

Special Requirements for Specific Provider Types

These provider types require Medicare enrollment and/or Wisconsin DQA (Division of Quality Assurance) certification with current provider information before submitting a Medicaid enrollment change in ownership:

- Ambulatory surgery centers
- CHCs (Community health centers)
- ESRD (End-stage renal disease) services providers
- Home health agencies
- Hospice providers
- Hospitals (inpatient and outpatient)
- Nursing homes
- Outpatient rehabilitation facilities
- Rehabilitation agencies
- RHCs (Rural health clinics)
- Tribal FQHCs (federally qualified health centers)

Additional Requirements for Providers Required to Use EVV

Providers required to use EVV when rendering certain services can ensure a successful transition by:

- Reviewing the EVV and Provider Agency Change of Ownership document, P-03819.
- Contacting Wisconsin EVV Customer Care at vdxc.contactevv@wisconsin.gov or 833-931-2035 Monday–Friday, 7 a.m.–6 p.m. Central Time.

Events ForwardHealth Considers a Change in Ownership

ForwardHealth defines a change in ownership as an event where a different party purchases (buys out) or otherwise obtains ownership or effective control over a practice or facility.

These events are considered a change in ownership and require the completion of a new provider enrollment application:

- Change from one type of business structure to another type of business structure. Business structures include the following:
  - Sole proprietorships
  - Corporations
  - Partnerships
  - LLCs (Limited liability companies)
- Change of name and TIN (Tax Identification Number) associated with the provider's submitted enrollment application (for example, EIN (Employer Identification Number))
- Change (addition or removal) of names identified as owners of the provider

Examples of a Change in Ownership

Examples of a change in ownership include:

- A sole proprietorship transfers title and property to another party.

- Two or more corporate clinics or centers consolidate, and a new corporate entity is created.
- There is an addition, removal, or substitution of a partner in a partnership.
- An incorporated entity merges with another incorporated entity.
- An unincorporated entity (sole proprietorship or partnership) becomes incorporated.

End Date of Previous Owner's Enrollment

The end date of the previous owner's enrollment will be one day prior to the effective date for the change in ownership. When the Wisconsin DHS (Department of Health Services) is notified of a change in ownership, the original owner's enrollment will automatically be end-dated.

Repayment Following a Change in Ownership

Medicaid-enrolled providers who sell or otherwise transfer their business or business assets must repay ForwardHealth for any incorrect payments or overpayments made to them. The new owner's application will be denied if the previous owner does not repay ForwardHealth for any incorrect payments or overpayments.

If necessary, ForwardHealth will hold the provider who receives the transfer of ownership before the final transfer of ownership responsible for repayment. The provider acquiring the business is responsible for contacting ForwardHealth to find out if they are liable under this provision.

The provider acquiring the business is responsible for full repayment within 30 days after receiving this notice from ForwardHealth.

Providers may send inquiries about determining of any pending liability:

Office of the Inspector General
PO Box 309
Madison WI 53701-0309

ForwardHealth has the authority to enforce these provisions within four years following the transfer of a business or business assets. Refer to Wis. Stat. § 49.45(21) for complete information.

Automatic Recoupment Following a Change in Ownership

ForwardHealth will automatically recover payments made to providers whose enrollment has ended in the ForwardHealth system due to a change in ownership. This automatic recoupment for previous owners occurs about 45 days after DHS is notified of the change in ownership. The recoupment will apply to all claims processed with DOS (Dates of Service) after the provider's new end date.

Providers Must Submit New Prior Authorization Requests After a Change in Ownership

Medicaid-enrolled providers must submit new PA (prior authorization) requests when there is a change in billing providers. Providers must submit new PA requests with the new billing provider's name and billing provider number. The expiration date of the new PA request will stay the same as the original PA request.

The provider must send this information to ForwardHealth with the new PA request:

- A copy of the original PA request, if possible
- The new PA request, including the required attachments and supporting documentation indicating the new billing provider's

name, address, and billing provider number
- A letter requesting to end date the original PA request (may be a photocopy), which should include:
  - The previous billing provider's name and billing provider number, if known
  - The new billing provider's name and billing provider number
  - The reason for the change of billing provider (The new billing provider may want to verify with the member that the services from the previous billing provider have ended. The new billing provider may include this verification in the letter.)
  - The requested effective date of the change

Submitting Claims After a Change in Ownership

The provider acquiring the business may submit claims with DOS on and after the change in ownership effective date.

Additional information on submission of timely filing requests or adjustment reconsideration requests is available.

How to Bill for a Hospital Stay That Spans a Change in Ownership

When a change in hospital ownership occurs, use the NPI that is current on the date of discharge. For example: A change in ownership occurs on July 1. A patient stay has DOS from June 26–July 2. The hospital submits the claim using the NPI effective July 1.

How to Bill for a Nursing Home Stay That Spans a Change in Ownership

When a change in nursing home ownership occurs, use the NPI that is current on the date of discharge. For example, a change in ownership occurs on July 1. A nursing home patient stay has DOS from June 26–July 2. The nursing home submits the claim using the NPI effective July 1.

For Further Questions

Providers with questions about changes in ownership may call Provider Services.

Topic #14317

Terminology to Know for Provider Enrollment

ForwardHealth adopted terminology due to the ACA (Affordable Care Act), which is included in the following table. This terminology is useful to providers during the provider enrollment and revalidation processes. Providers may refer to the Medicaid rule 42 C.F.R. § s. 455.101 for more information.

Terminology	Definition
Agent	Any person who has been delegated the authority to obligate or act on behalf of a provider.
Disclosing entity	A Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.
Federal health care programs	Federal health care programs include Medicare, Medicaid, Title XX, and Title XXI.
Other disclosing agent	Any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVII, or XX of the Act. This includes:

	▪ Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or HMO that participates in Medicare (Title XVIII) ▪ Any Medicare intermediary or carrier ▪ Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or XX of the Act
Indirect ownership	An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership in the disclosing entity.
Managing employee	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.
Ownership interest	The possession of equity in the capital, the stock, or the profits of the disclosing entity.
Person with an ownership or control interest	A person or corporation for which one or more of the following applies: ▪ Has an ownership interest totaling 5% or more in a disclosing entity ▪ Has an indirect ownership interest equal to 5% or more in a disclosing entity ▪ Has a combination of direct and indirect ownership interest equal to 5% or more in a disclosing entity ▪ Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or asset of the disclosing entity ▪ Is an officer or director of a disclosing entity that is organized as a corporation ▪ Is a person in a disclosing entity that is organized as a partnership
Subcontractor	▪ An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or, ▪ An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.
Re-enrollment	Re-enrollment of a provider whose Medicaid enrollment has ended for any reason other than sanctions or failure to revalidate may be re-enrolled as long as all licensure and enrollment requirements are met. Providers should note that when they re-enroll, application fees and screening activities may apply. Re-enrollment was formerly known as re-instate.
Revalidation	All enrolled providers are required to revalidate their enrollment information every three years to continue their participation with Wisconsin Medicaid. Revalidation was formerly known as recertification.

Note: Providers should note that the federal CMS (Centers for Medicare and Medicaid Services) requires revalidation at least every five years. However, Wisconsin Medicaid revalidates providers every three years.

Provider Numbers

Topic #3421

Provider Identification

Health Care Providers

Health care providers are required to indicate an NPI (National Provider Identifier) on enrollment applications and electronic and paper transactions submitted to ForwardHealth.

The NPI is a 10-digit number obtained through the NPPES (National Plan and Provider Enumeration System).

Providers should ensure that they have obtained an appropriate NPI prior to beginning their enrollment application. There are two kinds of NPIs:

- Entity Type 1 NPIs are for individuals who provide health care, such as physicians, dentists, and chiropractors.
- Entity Type 2 NPIs are for organizations that provide health care, such as hospitals, group practices, pharmacies, and home health agencies.

It is possible for a provider to qualify for both Entity Type 1 and Entity Type 2 NPIs. For example, an individual physical therapist may also be the owner of a therapy group that is a corporation and have two Wisconsin Medicaid enrollments — one enrollment as an individual physical therapist and the other enrollment as the physical therapy group. A Type 1 NPI for the individual enrollment and a Type 2 NPI for the group enrollment are required.

NPIs and classifications may be viewed on the NPPES website. The federal CMS (Centers for Medicare and Medicaid Services) website includes more information on Type 1 and Type 2 NPIs.

Health care providers who are federally required to have an NPI are responsible for obtaining the appropriate certification for their NPI.

Non-Healthcare Providers

Non-healthcare providers, such as SMV (specialized medical vehicle) providers, personal care agencies, and blood banks, are exempt from federal NPI requirements. Providers exempt from federal NPI requirements are assigned a Medicaid provider number once their enrollment application is accepted; they are required to indicate this Medicaid provider number on electronic and paper transactions submitted to ForwardHealth.

Topic #5096

Taxonomy Codes

Taxonomy codes are standard code sets used to provide information about provider type and specialty for the provider's enrollment. ForwardHealth uses taxonomy codes as additional data for correctly matching the NPI (National Provider Identifier) to the provider file.

Providers are required to use a taxonomy code when the NPI reported to ForwardHealth corresponds to multiple enrollments and the provider's practice location ZIP+4 code does not uniquely identify the provider.

Providers are allowed to report multiple taxonomy codes to ForwardHealth as long as the codes accurately describe the provider type and specialty for the provider's enrollment. When doing business with ForwardHealth, providers may use any one of the reported codes. Providers who report multiple taxonomy codes will be required to designate one of the codes as the primary taxonomy code; ForwardHealth will use this primary code for identification purposes.

Providers who wish to change their taxonomy code or add additional taxonomy codes may do so using the demographic maintenance tool. Most taxonomy code changes entered through the demographic maintenance tool will take effect in real time; providers may use the new codes immediately on transactions.

Omission of a taxonomy code when it is required as additional data to identify the provider will cause claims and other transactions to be denied or delayed in processing.

Note: Taxonomy codes do not change provider enrollment or affect reimbursement terms.

Topic #5097

ZIP Code

The ZIP code of a provider's practice location address on file with ForwardHealth must be a ZIP+4 code. The ZIP+4 code helps to identify a provider when the NPI (National Provider Identifier) reported to ForwardHealth corresponds to multiple enrollments and the reported taxonomy code does not uniquely identify the provider.

When a ZIP+4 code is required to identify a provider, omission of it will cause claims and other transactions to be denied or delayed in processing.

Providers may verify the ZIP+4 code for their address on the U.S. Postal Service website.

Provider Rights

Topic #208

A Comprehensive Overview of Provider Rights

Medicaid-enrolled providers have certain rights including:

- 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 (for example, the member may not be enrolled, may be enrolled only for limited benefits, or the ForwardHealth card may be invalid). Providers may confirm the current enrollment of the member by using one of the EVS (Enrollment Verification System) methods, including calling Provider Services.

Topic #207

Ending Participation

Providers other than home health agencies and nursing facilities may terminate participation in ForwardHealth according to Wis. Admin. Code § DHS 106.05.

Providers choosing to withdraw should promptly notify their members to give them ample time to find another provider.

When withdrawing, the provider is required to do the following:

- Provide a written notice of the decision at least 30 days in advance of the termination.
- Indicate the effective date of termination.

Providers will not receive reimbursement for nonemergency services provided on and after the effective date of termination. Voluntary termination notices can be sent to the following address:

Wisconsin Medicaid
Provider Enrollment
313 Blettner Blvd
Madison WI 53784

If the provider fails to specify an effective date in the notice of termination, ForwardHealth may terminate the provider on the date the notice is received.

Topic #209

Hearing Requests

A provider who wishes to contest a Wisconsin DHS (Department of Health Services) action or inaction for which due process is

required under Wis. Stat. ch. DHS 227, may request a hearing by writing to the DHA (Division of Hearings and Appeals).

A provider who wishes to contest DMS (Division of Medicaid Services)'s notice of intent to recover payment (for example, to recoup for overpayments discovered in an audit by DMS) is required to request a hearing on the matter within the time period specified in the notice. The request, which must be in writing, should briefly summarize the provider's basis for contesting DHS's decision to withhold payment.

Refer to Wis. Admin. Code ch. DHS 106 for detailed instructions on how to file an appeal.

If a timely request for a hearing is not received, DHS may recover those amounts specified in its original notice from future amounts owed to the provider.

Note: Providers are not entitled to administrative hearings for billing disputes.

Topic #210

Limiting the Number of Members

If providers choose to limit the number of members they see, they cannot accept a member as a private-pay patient. Providers should instead refer the member to another ForwardHealth provider.

Persons applying for or receiving benefits are protected against discrimination based on race, color, national origin, sex, religion, age, disability, or association with a person with a disability.

Topic #206

Requesting Discretionary Waivers and Variances

In rare instances, a provider or member may apply for, and DMS (Division of Medicaid Services) will consider applications for, a discretionary waiver or variance of certain rules in Wis. Admin. Code chs. DHS 102, 103, 104, 105, 107, and 108. Rules that are not considered for a discretionary waiver or variance are included in Wis. Admin. Code § DHS 106.13.

Waivers and variances are not available to permit coverage of services that are either expressly identified as noncovered or are not expressly mentioned in Wis. Admin. Code ch. DHS 107.

Requirements

A request for a waiver or variance may be made at any time; however, all applications must be made in writing to DMS. All applications are required to specify the following:

- The rule from which the waiver or variance is requested.
- The time period for which the waiver or variance is requested.
- If the request is for a variance, the specific alternative action proposed by the provider.
- The reasons for the request.
- Justification that all requirements for a discretionary waiver or variance would be satisfied.

DMS may also require additional information from the provider or the member prior to acting on the request.

Application

DMS may grant a discretionary waiver or variance if it finds that all of the following requirements are met:

- The waiver or variance will not adversely affect the health, safety, or welfare of any member.
- Either the strict enforcement of a requirement would result in unreasonable hardship on the provider or on a member, or an alternative to a rule is in the interests of better care or management. An alternative to a rule would include a new concept, method, procedure or technique, new equipment, new personnel qualifications, or the implementation of a pilot project.
- The waiver or variance is consistent with all applicable state and federal statutes and federal regulations.
- Federal financial participation is available for all services under the waiver or variance, consistent with the Medicaid state plan, federal CMS (Centers for Medicare and Medicaid Services), and other applicable federal program requirements.
- Services relating to the waiver or variance are medically necessary.

To apply for a discretionary waiver or variance, providers are required to send their application to the following address:

Division of Medicaid Services
Waivers and Variances
PO Box 309
Madison WI 53701-0309

Sanctions

Topic #211

Intermediate Sanctions

According to Wis. Admin. Code § DHS 106.08(3), Wisconsin DHS (Department of Health Services) may impose intermediate sanctions on providers who violate certain requirements. Common examples of sanctions that DHS may apply include the following:

- Review of the provider's claims before payment
- Referral to the appropriate peer review organization, licensing authority, or accreditation organization
- Restricting the provider's participation in BadgerCare Plus
- Requiring the provider to correct deficiencies identified in a DHS audit

Prior to imposing any alternative sanction under this section, DHS will issue a written notice to the provider in accordance with Wis. Admin. Code § DHS 106.12.

Any sanction imposed by DHS may be appealed by the provider under Wis. Admin. Code § DHS 106.12. Providers may appeal a sanction by writing to DHA (Division of Hearings and Appeals).

Topic #212

Involuntary Termination

Wisconsin DHS (Department of Health Services) may suspend or terminate the Medicaid enrollment of any provider according to Wis. Admin. Code § DHS 106.06.

The suspension or termination may occur if both of the following apply:

- DHS finds that any of the grounds for provider termination are applicable.
- The suspension or termination will not deny members access to services.

Reasonable notice and an opportunity for a hearing within 15 days will be given to each provider whose enrollment is terminated by DHS. Refer to Wis. Admin. Code § DHS 106.07 for detailed information regarding possible sanctions.

In cases where Medicare enrollment is required as a condition of enrollment with Wisconsin Medicaid, termination from Medicare results in automatic termination from Wisconsin Medicaid.

Topic #213

Sanctions for Collecting Payment From Members

Under state and federal laws, if a provider inappropriately collects payment from an enrolled member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid enrollment. In addition, the provider may also be fined not more than $25,000, or imprisoned not more than five years, or both, pursuant to 42 USC § 1320a-7b(d) or Wis. Stat. § 49.49(3m).

There may be narrow exceptions on when providers may collect payment from members.

Topic #214

Withholding Payments

Wisconsin DHS (Department of Health Services) may withhold full or partial Medicaid provider payments without prior notification if, as the result of any review or audit, DHS finds reliable evidence of fraud or willful misrepresentation.

Reliable evidence of fraud or willful misrepresentation includes, but is not limited to, the filing of criminal charges by a prosecuting attorney against the provider or one of the provider's agents or employees.

DHS is required to send the provider a written notice within five days of taking this action. The notice will generally set forth the allegations without necessarily disclosing specific information about the investigation.

Reimbursement

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Archive Date:10/01/2026

Reimbursement:Amounts

Topic #258

Acceptance of Payment

The amounts allowed as payment for covered services must be accepted as payment in full. Therefore, total payment for the service (for example, any amount paid by other health insurance sources, any BadgerCare Plus or Medicaid copay or spenddown amounts paid by the member, and any amount paid by BadgerCare Plus, Medicaid, or HDAP (Wisconsin HIV Drug Assistance Program)) may not exceed the allowed amount. As a result, providers may not collect payment from a member or authorized person acting on behalf of the member, for the difference between their usual and customary charge and the allowed amount for a service (for example, balance billing).

Other health insurance payments may exceed the allowed amount if no additional payment is received from the member or BadgerCare Plus, Medicaid, or HDAP.

Topic #8277

Additional Reimbursement for Reporting Body Mass Index

ForwardHealth is collecting BMI (body mass index) data on children enrolled in BadgerCare Plus or Wisconsin Medicaid to gather baseline information for future policy initiatives.

ForwardHealth will reimburse an additional $10 to providers and clinics for reporting BMI on professional claims for routine office visits and preventive services for members 2 to 18 years old on the DOS (date of service).

Providers who are eligible to receive the additional reimbursement include the following:

- HealthCheck agencies
- Nurse midwives
- Nurse practitioners
- Physician assistants
- Physicians

Reporting Body Mass Index on Claims

For the additional reimbursement, CPT (Current Procedural Terminology) Category II procedure code 3008F (Body mass index, documented) is required on the claim in addition to an office visit procedure code. An ICD diagnosis reporting the pediatric BMI outcome must be associated with code 3008F. A $10 minimum is required to be billed for procedure code 3008F.

Providers are required to maintain records that fully document the basis of charges upon which all claims for additional reimbursement payments are made.

Reimbursement

Providers are paid $10 per billing provider, per child, per calendar year for reporting BMI for members in fee-for-service.

Payments for reporting BMI will appear on the RA (Remittance Advice) under EOB (Explanation of Benefits) code 9944, "Pricing Adjustment - Incentive Pricing."

Topic #647

Ancillary Providers

Wisconsin Medicaid covers counseling services (for example, weight management, diabetic, smoking cessation, and prenatal services), coordination of care services, and delegated medical acts (for example, giving injections or immunizations, checking medications, changing dressings) provided by ancillary providers if all of the following are true:

- The services are provided under the **direct, immediate, on-site** supervision of a physician.
- The services are pursuant to the physician's plan of care.
- The supervising physician has not also provided Medicaid reimbursable services during the same office or outpatient E&M (evaluation and management) visit.

Examples of ancillary providers include non-Medicaid enrollable health care professionals such as staff nurses, dietician counselors, nutritionists, health educators, genetic counselors, and some nurse practitioners. (Nurse practitioners, nurse midwives, and anesthetists who are Medicaid enrolled should refer to their service-specific area for billing information.)

"On-site" means that the supervising physician is in the same building in which services are being provided and is immediately available for consultation or, in the case of emergencies, for direct intervention. The physician is not required to be in the same room as the ancillary provider, unless dictated by medical necessity and good medical practice.

Since ancillary providers are not Medicaid-eligible providers, claims for these services must be submitted under the supervising physician's NPI (National Provider Identifier) using the lowest appropriate level office or outpatient visit procedure code or other appropriate CPT (Current Procedural Terminology) code for the service performed. These services are not to be billed in addition to or combined with the physician service if the physician sees the patient during the same visit.

Note: Physician assistants are not considered ancillary staff, as they can bill Medicaid directly.

Topic #694

Billing Service and Clearinghouse Contracts

According to Wis. Admin. Code § DHS 106.03(5)(c)2, contracts with outside billing services or clearinghouses may not be based on commission in which compensation for the service is dependent on reimbursement from BadgerCare Plus. This means compensation must be unrelated, directly or indirectly, to the amount of reimbursement or the number of claims and is not dependent upon the actual collection of payment.

Topic #8117

Electronic Funds Transfer

EFT (Electronic funds transfer) allows ForwardHealth to directly deposit payments into a provider's designated bank account for a more efficient delivery of payments than the current process of mailing paper checks. EFT is secure, eliminates paper, and reduces the uncertainty of possible delays in mail delivery.

Only in-state and border-status providers who submit claims and MCOs (managed care organizations) are eligible to receive EFT payments.

Provider Exceptions

EFT payments are not available to the following providers:

- In-state emergency providers
- Out-of-state providers
- Out-of-country providers
- SMV (Specialized medical vehicle) providers during their provisional enrollment period

Enrolling in Electronic Funds Transfer

A ForwardHealth Portal account is required to enroll into EFT as all enrollments must be completed via a secure Provider Portal account or a secure MCO Portal account. Paper enrollments are not accepted. A separate EFT enrollment is required for each financial payer a provider bills.

Providers who do not have a Portal account may Request Portal Access online. Providers may also call the Portal Helpdesk for assistance in requesting a Portal account.

The following guidelines apply to EFT enrollment:

- Only a Portal Administrator or a clerk who has been assigned the EFT role on the Portal may complete the EFT enrollment information.
- Organizations can revert back to receiving paper checks by disenrolling in EFT.
- Organizations may change their EFT information at any time.
- Organizations will continue to receive their RA (Remittance Advice) as they do currently.

Refer to the Electronic Funds Transfer User Guide on the User Guides page of the Portal for instructions and more information about EFT enrollment.

Providers will continue to receive payment via paper check until the enrollment process moves into Active status and the provider's ForwardHealth EFT enrollment is considered complete.

Recoupment and Reversals

Enrollment in EFT does not change the current process of recouping funds. Overpayments and recoupment of funds will continue to be conducted through the reduction of payments.

Note: Enrolling in EFT does not authorize ForwardHealth to make unauthorized debits to the provider's EFT account; however, in some instances an EFT reversal of payment may be necessary. For example, if the system generates a payment twice or the amount entered manually consists of an incorrect value (for example, a decimal point is omitted creating a $50,000 keyed value for a $500 claim), a reversal will take place to correct the error and resend the correct transaction value. ForwardHealth will notify the designated EFT contact person of an EFT reversal if a payment is made in error due to a system processing or manual data entry error.

Problem Resolution

If payment is not deposited into the designated EFT account according to the ForwardHealth payment cycle, providers should first check with their financial institution to confirm the payment was received. If the payment was not received, providers should then call Provider Services to resolve the issue and payment by paper check will be reinstated until the matter has been resolved.

Topic #897

Fee Schedules

Maximum allowable fee information is available on the Max Fee Schedules page of the ForwardHealth Portal in the following forms:

- An interactive maximum allowable fee schedule
- Downloadable fee schedules by service area only in TXT (text) or CSV (comma separated value) files

Policy information is not displayed in the fee schedules. Providers should refer to their specific service area in the Online Handbook for more information about coverage policy related to a specific procedure code.

Certain fee schedules are interactive. On the interactive fee schedule, providers have more search options for looking up some coverage information, as well as the maximum allowable fees, as appropriate, for reimbursable HCPCS (Healthcare Common Procedure Coding System), CPT (Current Procedural Terminology), or CDT (Current Dental Terminology) procedure codes for most services.

Providers have the ability to independently search by:

- A single HCPCS, CPT, or CDT procedure code
- Multiple HCPCS, CPT, or CDT procedure codes
- A pre-populated code range
- A service area (Service areas listed in the interactive fee schedule more closely align with the provider service areas listed in the Online Handbook, including the WCDP (Wisconsin Chronic Disease Program) programs and WWWP (Wisconsin Well Woman Program).)

The downloadable fee schedules, which are updated monthly, provide basic maximum allowable fee information by provider service area.

Through the interactive fee schedule, providers can export their search results for a single code, multiple codes, a code range, or by service area. The export function of the interactive fee schedule will return a .zip file that includes seven CSV files containing the results.

Note: The interactive fee schedule will export all associated information related to the provider's search criteria except the procedure code descriptions.

Providers may call Provider Services in the following cases:

- The ForwardHealth Portal is not available.
- There is uncertainty as to which fee schedule should be used.
- The appropriate fee schedule cannot be found on the Portal.
- To determine coverage or maximum allowable fee of procedure codes not appearing on a fee schedule.

Topic #19777

Targeted Reimbursement Rate Increase

In accordance with a provision of the 2015-17 biennial state budget (2015 Wisconsin Act 55), ForwardHealth implemented a targeted enhanced reimbursement rate for pediatric dental care and certain adult dental services. The targeted reimbursement rate applies to all Medicaid-enrolled provider types eligible to render dental services and applies to services rendered in Brown, Marathon, Polk, and Racine counties. The rendering provider's practice location is considered the county where the services are

rendered, not the county of the billing provider or the member.

The reimbursement rate increase applies to all Medicaid-enrolled provider types eligible to render dental services in a target county; however, the reimbursement rate increase does not apply to dental services billed through a federally qualified health center. The reimbursement rate applies to services provided fee-for-service and via managed care.

If the rendering provider practices in both a target county and non-target county, the rendering provider is required to obtain separate Medicaid enrollment for both the target county and the non-target county. The address of the rendering provider should be indicated in the appropriate field on submitted claims, including the ZIP code matching the Medicaid enrollment address. Rendering providers who need to set up separate Medicaid enrollment for separate locations can begin the process as follows:

- Go to the Provider Enrollment page.
- Click the Start or Continue Your Enrollment Application link to begin a new Medicaid enrollment.

Providers with questions regarding the enrollment process can call ForwardHealth Provider Services.

Maximum Allowable Fees

ForwardHealth reimburses the lesser of the provider's billed amount or the increased reimbursement rate. The maximum daily reimbursement rate policy applies only for services eligible for the rate increase.

The maximum allowable fee schedule includes all current reimbursement rates. Providers should indicate their usual and customary charges when submitting claims for services.

Topic #648

Health Professional Shortage Areas

Enhanced reimbursement is provided to Medicaid-enrolled primary care providers and emergency medicine providers for selected services when one or both of the following apply:

- The rendering or billing provider is located in a HPSA (Health Professional Shortage Area)-eligible ZIP code.
- The member has a residential address (according to enrollment records) within a HPSA-eligible ZIP code.

Primary care providers and emergency medicine providers include the following:

- Physicians with specialties of general practice, obstetrics and gynecology, family practice, internal medicine, or pediatrics
- Physician assistants
- Nurse practitioners
- Nurse midwives

Standard enhanced reimbursement for HPSA-eligible primary care procedures is an additional 20% of the physician maximum allowable fee. The enhanced reimbursement for HPSA-eligible obstetrical procedures is an additional 50% of the physician maximum allowable fee.

Health Professional Shortage Area-Eligible Procedure Codes

Providers may use HPSA modifier AQ (Physician providing a service in a HPSA) with the following categories of procedure codes (while the AQ modifier is defined for physicians only, any Medicaid HPSA-eligible provider may use the modifier when appropriate):

- E&M (evaluation and management)Office Visits, New Patient

- E&M Office Visits, Established Patient
- E&M Home Visits, New Patient
- E&M Home Visits, Established Patient
- Emergency Department Services
- Newborn Care
- Preventive Medicine
- Obstetric Care
- Vaccines

Use of Modifier AQ

To obtain the HPSA-enhanced reimbursement, providers are required to indicate modifier AQ along with the appropriate procedure code on the claim. (Refer to the Pediatric Services Performed in a Health Professional Shortage Area section of this topic for information regarding use of modifier AQ for pediatric services.)

Medicare Crossover Claims

Medicare HPSA policy differs from Wisconsin Medicaid's HPSA policy in many ways. Medicaid covers more services than **Medicare**, allows a broader range of providers to receive the incentive payment, pays a higher bonus, and defines HPSA differently than **Medicare**. Most importantly, Wisconsin Medicaid pays the enhanced reimbursement to physicians, physician assistants, nurse practitioners, and nurse midwives while **Medicare** pays the HPSA incentive payment only to physicians.

For these reasons, Medicare crossover claims that are eligible for the Medicaid HPSA incentive payment may not automatically be forwarded to ForwardHealth from **Medicare**. Providers may have to submit these claims directly to ForwardHealth.

Antepartum Care Visits Performed in a Health Professional Shortage Area

If a provider renders three or fewer antepartum care visits, the provider is required to bill the appropriate E&M service code with modifier TH (Obstetrical treatment/services, prenatal or postpartum) listed first and the HPSA modifier AQ listed second.

If a provider renders three or fewer antepartum care visits and the rendering provider is a licensed midwife, the provider is required to bill procedure code 59425 with modifier 52 (representing antepartum care only; less than 4 visits) listed first and the HPSA modifier AQ listed second.

Pediatric Services Performed in a Health Professional Shortage Area

Pediatric services include office and other outpatient services and emergency department services for members 18 years of age and younger.

Reimbursement for eligible procedure codes with HPSA modifier AQ automatically includes the pediatric incentive payment, when applicable, since the incentive payment is based on the age of the member. Providers should not submit claims with modifier TJ in addition to HPSA modifier AQ for the same procedure code. Providers should *only* include the HPSA modifier in situations where both of these modifiers apply. Wisconsin Medicaid will determine the member's age and determine the proper HPSA reimbursement for these procedure codes.

Modifier TJ may be used when submitting claims for eligible services in situations that do not qualify for HPSA-enhanced reimbursement.

HealthCheck Services Not Eligible for Health Professional Shortage Area Incentive Payment

Procedure codes 99381-99385 and 99391-99395 are **not** eligible for HPSA incentive payments, regardless of the billing or rendering provider's or member's location, since reimbursement for these procedure codes includes enhanced reimbursement for HealthCheck services.

Claims Submitted Inappropriately for Health Professional Shortage Area Incentive Payment

Providers who submit claims for the HPSA-enhanced reimbursement inappropriately are reimbursed the lesser of the provider's usual and customary fee or the maximum allowable fee, assuming that all other ForwardHealth policies are followed. The enhanced reimbursement amount is not paid when the HPSA modifier is submitted but the provider or member is not eligible for HPSA designation.

Health Professional Shortage Areas

Note: The county is listed for information purposes only. Not all ZIP codes in a county may be included in the HPSA.

Name	County	ZIP Codes
Adams County	Adams	Entire county: 53910, 53920, 53927, 53934, 53936, 53952, 53964, 53965, 54457, 54613, 54921, 54930, 54943, 54966
Augusta/Osseo	Eau Claire	54722, 54741, 54758, 54770
	Jackson	54635, 54741, 54758
	Trempealeau	54758, 54770
Baldwin	St. Croix	54002, 54013, 54015, 54017, 54026, 54027, 54028, 54749, 54767
	Dunn	54749, 54751
Bayfield	Ashland	54850
	Bayfield	54814, 54827, 54844, 54891
Beloit	Rock	53511, 53512
Boscobel	Crawford	53805, 53826, 53831, 54657
	Grant	53518, 53573, 53801, 53804, 53805, 53809, 53816, 53821, 53827
	Richland	53518, 53573
Burnett County	Burnett	Entire county: 54801, 54813, 54830, 54837, 54840, 54845, 54853, 54871, 54872, 54893
Central Trempealeau	Trempealeau	54616, 54747, 54760, 54773
Chetek/Colfax	Barron	54004, 54728, 54733, 54757, 54762, 54812, 54889, 54895
	Dunn	54005, 54725, 54730, 54734, 54749, 54751, 54757, 54763, 54772
Chilton/New Holstein/Brillion	Calumet	53014, 53042, 53049, 53061, 53062, 54110, 54129, 54130
Clark County	Clark	Entire county: 54405, 54420, 54421, 54422, 54425, 54436, 54437, 54446, 54456, 54460, 54466, 54479, 54488, 54493, 54498, 54746, 54754, 54768, 54771
Clintonville/Marion	Outagamie	54106, 54170, 54922
	Shawano	54928, 54929, 54950
	Waupaca	54922, 54929, 54949, 54950
Coon Valley/Chaseburg	La Crosse	54619, 54623, 54667
	Vernon	54621, 54623, 54667
Darlington/Schullsburg	Green	53504, 53516
	Lafayette	53504, 53516, 53530, 53541, 53565, 53586, 53587
Durand	Buffalo	54736
	Dunn	54736, 54737, 54739, 54740, 54751, 54755
	Pepin	54721, 54736, 54759, 54769
	Pierce	54740, 54750, 54761, 54767
Eastern Marinette/Southern Menomonie	Marinette	54143, 54157, 54159, 54177

Elcho	Langlade	54424, 54428, 54435, 54462, 54485
	Oneida	54435, 54463
Florence County	Florence	Entire county: 54103, 54120, 54121, 54151, 54542
Forest County	Forest	Entire county: 54103, 54104, 54465, 54511, 54520, 54541, 54542, 54562, 54566
Frederic/Luck	Polk	54829, 54837, 54853
Galesville/Trempealeau	Trempealeau	54612, 54625, 54627, 54630, 54661
Hayward/Radisson	Bayfield	54517, 54821, 54832, 54839, 54873
	Sawyer	54817, 54835, 54843, 54862, 54867, 54876, 54896
	Washburn	54843, 54875, 54876
Hillsboro	Juneau	53929, 53968
	Monroe	53929, 54638, 54648, 54651, 54670
	Richland	53924, 53941, 54634
	Sauk	53968
	Vernon	53929, 53968, 54634, 54638, 54639, 54651
Hurley/Mercer	Iron	54534, 54536, 54545, 54547, 54550, 54559
Kenosha	Kenosha	53140, 53142, 53143, 53144
Kewaunee City/Algoma	Kewaunee	54201, 54205, 54216, 54217
Lancaster/Fennimore	Grant	53569, 53802, 53804, 53806, 53809, 53810, 53813, 53820, 53825
Land O'Lakes/Presque Isle	Vilas	54540, 54547, 54557
Markesan/Kingston	Green Lake	53923, 53926, 53939, 53946, 53947, 53949
Marquette County	Marquette	Entire county: 53920, 53926, 53930, 53949, 53952, 53953, 53954, 54960, 53964, 54982
Menominee County	Menominee	Entire county: 54135, 54150, 54416
Milwaukee	Milwaukee	53203, 53204, 53205, 53206, 53208, 53209, 53210, 53212, 53215, 53216, 53218, 53233
Minong/Solon Springs	Douglas	54820, 54830, 54838, 54849, 54859, 54873
	Washburn	54859, 54875, 54888
Mondovi	Buffalo	54610, 54622, 54736, 54747, 54755
	Pepin	54755
Mountain/White Lake	Langlade	54430, 54465, 54491
	Oconto	54112, 54114, 54138, 54149, 54161, 54174, 54175, 54491
Oconto/Oconto Falls	Oconto	54101, 54124, 54139, 54141, 54153, 54154, 54171, 54174
	Shawano	54127
Platteville/Cuba City	Grant	53554, 53807, 53811, 53818, 53820
	Iowa	53554, 53580
	Lafayette	53510, 53803, 53807, 53811, 53818
Portage/Pardeeville	Columbia	53901, 53911, 53923, 53928, 53932, 53935, 53954, 53955, 53956, 53960, 53969
	Dodge	53956, 53957

Price/Mellen	Ashland	54514, 54527, 54546
	Iron	54552
	Price	Entire county: 54459, 54513, 54514, 54515, 54524, 54530, 54537, 54552, 54555, 54556, 54564
Pulaski	Brown	54162
	Shawano	54162, 54165
	Oconto	54162
Rusk County	Rusk	Entire county: 54526, 54530, 54563, 54728, 54731, 54745, 54757, 54766, 54817, 54819, 54835, 54848, 54868, 54895
Sister Bay/Washington Island	Door	54202, 54210, 54211, 54212, 54234, 54246
Sparta	Monroe	54615, 54619, 54648, 54656
Spooner/Shell Lake	Washburn	54801, 54813, 54817, 54870, 54871, 54875, 54888
Spring Green/Plain	Richland	53556
	Sauk	53556, 53577, 53578, 53583, 53588, 53937, 53943, 53951
Stanley/Cornell	Chippewa	54726, 54727, 54732, 54745, 54757, 54766, 54768
	Eau Claire	54722, 54726, 54742, 54768
Sturgeon Bay	Door	54201, 54202, 54204, 54209, 54213, 54217, 54235
Taylor County	Taylor	Entire county: 54422, 54425, 54433, 54434, 54439, 54447, 54451, 54460, 54470, 54480, 54490, 54498, 54766, 54768, 54771
Tigerton/Birnamwood	Marathon	54408, 54414, 54427, 54429, 54440, 54499
	Shawano	54409, 54414, 54416, 54427, 54450, 54486, 54499
	Waupaca	54486, 54926, 54945
Tomahawk	Lincoln	54435, 54442, 54487, 54501, 54564
	Oneida	54487, 54529, 54564
Wausau, City of	Marathon	54401, 54403
Waushara	Waushara	54909, 54923, 54930, 54940, 54943, 54960, 54965, 54966, 54967, 54970, 54981, 54982, 54984
Western Marinette	Marinette	54102, 54104, 54112, 54114, 54119, 54125, 54151, 54156, 54159, 54161, 54177

Topic #3510

HealthCheck Services

Wisconsin Medicaid provides enhanced reimbursement for comprehensive health screens for members under age 21 when those screens are billed as HealthCheck services (CPT (Current Procedural Terminology) procedure codes 99381–99385 and 99391–99395).

Topic #260

Maximum Allowable Fees

Maximum allowable fees are established for most covered services. Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

Providers are reimbursed at the lesser of their billed amount and the maximum allowable fee for the procedure.

Topic #649

Maximum Daily Reimbursement

ForwardHealth reimbursement for services performed on the same DOS (date of service) for the same member by the same rendering provider is limited to $2,331.37 for services rendered by the following providers:

- Anesthesiologists
- Anesthesiologist Assistants
- Certified Registered Nurse Anesthetists
- Licensed midwives
- Nurse Midwives
- Nurse Practitioners
- Pharmacists
- Physician assistants
- Physicians
- Podiatrists

The maximum daily reimbursement amount does not apply to physician-administered drugs and DME (durable medical equipment).

Dental services, including radiographs (when submitted on a dental claim) and oral surgery emergency services, are subject to a different maximum daily reimbursement amount.

ForwardHealth remittance information will indicate when the maximum daily reimbursement amount has been met.

Requests to Exceed Maximum Daily Reimbursement Limit

Providers may request additional reimbursement to exceed the maximum daily reimbursement limit when both of the following criteria are met:

1. A surgery exceeds six hours or anesthesia exceeds 7.5 hours.
2. The Medicaid-allowed amount for the services meets or exceeds the maximum daily reimbursement limit.

Submitting Supporting Documentation

To request reimbursement in excess of the maximum daily reimbursement limit, providers are required to submit the following information on the claim:

- In the Notes field, indicate "request for additional reimbursement for surgery in excess of 6 hours," or "request for additional reimbursement for anesthesia services in excess of 7.5 hours."
- Attach supporting documentation to the claim that clearly indicates the length of the surgery or the length of the anesthesia services, such as a post-operative report.

Providers are reminded of the following options for providing supporting documentation along with a claim:

- On paper with supporting documentation submitted on paper.
- Electronically using DDE (Direct Data Entry) through the Portal, PES (Provider Electronic Solutions) transactions, or 837 Health Care Claim electronic transactions. For more information, refer to the User Guides page of the ForwardHealth Portal.

- Electronically with an indication that supporting documentation will be submitted separately on paper. For more information, refer to the ForwardHealth Companion Guides.

Topic #866

Nurse Practitioners

Nurse practitioners are reimbursed the lesser of the nurse practitioner's usual and customary charge for a service or the physician's maximum allowable fee for the procedure. Nurse practitioners use the physician maximum allowable fee schedule.

Topic #650

Pediatric Services

Wisconsin Medicaid provides an enhanced reimbursement rate for office and other outpatient services (CPT (Current Procedural Terminology) procedure codes 99202–99215 and HCPCS (Healthcare Common Procedure Coding System) procedure code G2212) and emergency department services (CPT procedure codes 99281–99285) for members 18 years of age and younger. The enhanced reimbursement rates are indicated on the physician services maximum allowable fee schedule.

To obtain the enhanced reimbursement for members under 18 years old, indicate the applicable procedure code and modifier TJ (Program group, child and/or adolescent) on the claim.

Topic #651

Physician Assistants

Wisconsin Medicaid generally reimburses physician assistants 90% of the payment allowed for the physician who would have otherwise performed the service. Physician assistants are paid 100% of the physician's maximum fee for HealthCheck screens, injections, immunizations, lab handling fees, and select diagnostic procedures.

Physician assistants who are enrolled as Wisconsin Medicaid providers can submit claims to ForwardHealth as billing providers.

Topic #652

Physicians

Wisconsin Medicaid reimburses physicians the lesser of the physician's billed amount for a service or Wisconsin Medicaid's maximum allowable fee.

Topic #553

Psychiatric and Substance Abuse Services

To be reimbursed for psychiatric services (CPT (Current Procedural Terminology) codes 90785-90853, 90865-90899), physicians are required to be certified as a psychiatrist pursuant to Wis. Admin. Code DHS 105.22(1)(a).

Any Medicaid-enrolled physician may be reimbursed for substance abuse services.

Topic #7777

Reimbursement Rates for Professional Services

For most professional services, ForwardHealth reimburses no more than Medicare rates. However, for select professional services, the rate for the service is greater than the Medicare rate when provided to members 18 years of age and younger on the date of service.

Providers should refer to the Medicaid maximum allowable fee schedule on the ForwardHealth Portal for current reimbursement rates.

Topic #13297

Reimbursement for Office-Based Services Provided in a Hospital or an Ambulatory Surgery Center

ForwardHealth reduces reimbursement to physicians and other professional service providers for services that are typically provided in an office-based setting when those services are instead provided in a hospital (POS (place of service) code 21 or 22) or an ASC (ambulatory surgery center) (POS code 24). The reduced reimbursement is intended to account for the lower overhead costs typically realized by physicians and other professional services providers when services are provided in a hospital or an ASC.

ForwardHealth uses the Medicare Physician Fee Schedule identification of professional services with reduced reimbursement when provided in a facility setting.

Affected services are reimbursed at the full maximum allowable fee when provided in an allowable POS other than 21, 22, or 24.

Reimbursement reductions for E&M (Evaluation and Management) services only apply for members who are 19 years of age or older on the DOS (date of service). For these select services, providers are reimbursed at the full maximum allowable fee when the service is rendered to members who are 18 years of age or younger on the DOS, regardless of POS.

Topic #23340

Reimbursement for Pharmacists Under Collaborative Practice Agreement

Reimbursement for services provided by a pharmacist will be made as a percentage of a physician's payment. Payment will be made at the lesser of the usual and customary charge or no more than 90 percent of the physician fee for that procedure. Certain services are exceptions to the rule and will be paid at the full physician fee including immunization injections, HealthCheck visits, and select diagnostic procedures.

Topic #653

Residents

Wisconsin Medicaid reimburses residents for physician services when:

- The resident is fully licensed to practice medicine and has obtained an NPI (National Provider Identifier).
- The service can be separately identified from those services that are required as part of the training program.
- The resident is operating independently and not under the direct supervision of a physician.
- The service is provided in a clinic, an outpatient hospital, or emergency department setting.

The reimbursement for residents is identical to other licensed physicians.

Topic #655

Supervising Physicians of Interns and Residents

Wisconsin Medicaid reimburses supervising physicians in a teaching setting for the services provided by interns and residents if those services are supervised, provided as part of the training program, and billed under the supervising physician's NPI (National Provider Identifier). The supervising physician must provide personal and identifiable direction to interns or residents who are participating in the care of the member. This direction includes any or all of the following:

- Reviewing the member's medical history or physical examination
- Personally examining the member within a reasonable period after admission
- Confirming or revising diagnoses
- Determining the course of treatment to be followed
- Making frequent review of the member's progress

The notes must indicate that the supervising physician personally reviewed the member's medical history, performed a physical and/or psychiatric examination, confirmed or revised the diagnosis, and discharged the member.

Topic #656

Surgical Procedures

Surgical procedures performed by the same physician, for the same member, on the same DOS (date of service) must be submitted on the same claim form. Surgeries that are billed on separate claim forms are denied.

Certain surgical procedures billed on professional claims (the 837P (837 Health Care Claim: Professional) transaction or the 1500 Health Insurance Claim Form ((02/12))) may be reimbursed only when performed in an inpatient hospital or an ASC (ambulatory surgery center).

Reimbursement for most surgical procedures includes reimbursement for preoperative and postoperative care days. Preoperative and postoperative surgical care includes the preoperative evaluation or consultation, postsurgical E&M (evaluation and management) services (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% of ForwardHealth's usual surgeon rate for the specific procedure they have 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% 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% 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% of the maximum allowable fee for the primary procedure, 50% for the secondary procedure, 25% for the tertiary procedure, and 13% for all subsequent procedures. The Medicaid-allowed surgery with the greatest usual and customary charge on the claim is reimbursed as the primary surgical procedure, the next highest is the secondary surgical procedure, etc.

ForwardHealth permits full maximum allowable payments for surgeries that are performed on the same DOS but at **different** surgical sessions. For example, if a provider performs a sterilization on the same DOS as a delivery, the provider may be reimbursed the full maximum allowable fee for both procedures if performed at different times (and if all of the billing requirements were met for the sterilization).

To obtain full reimbursement, submit a claim for all the surgeries performed on the same DOS that are being billed for the member. Then submit an Adjustment/Reconsideration Request (F-13046 (02/2025)) 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% of ForwardHealth's maximum allowable fee for the service. The second delivery is reimbursed at 50%, the third at 25%, and subsequent deliveries at 13% each.

In the event of a combination of vaginal and Cesarean deliveries, the delivery with the largest billed amount is reimbursed at 100%, the delivery with the next largest at 50%, 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%, the second Cesarean delivery at 50%, and the vaginal delivery at 25%.

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 (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 that fall within the range of established pre-care and post-care days for the procedure(s) being performed are denied unless they indicate a circumstance or diagnosis code unrelated to the surgical procedure.

For the number of preoperative and postoperative care days applied to a specific procedure code, call Provider Services.

Collecting Payment From Members

Topic #227

Conditions That Must Be Met

A member may request a noncovered service, a covered service for which PA (prior authorization) was denied (or modified), or a service that is not covered under the member's limited benefit category. The charge for the service may be collected from the member if the following conditions are met **prior** to the delivery of that service:

- The member accepts responsibility for payment.
- The provider and member make payment arrangements for the service.

Providers are strongly encouraged to obtain a **written** statement in advance documenting that the member has accepted responsibility for the payment of the service.

Furthermore, the service must be separate or distinct from a related, covered service. For example, a vision provider may provide a member with eyeglasses but then, upon the member's request, provide and charge the member for anti-glare coating, which is a noncovered service. Charging the member is permissible in this situation because the anti-glare coating is a separate service and can be added to the lenses at a later time.

Topic #538

Cost Sharing

According to federal regulations, providers cannot hold a member responsible for any commercial or Medicare cost-sharing amount such as coinsurance, copay, or deductible. Therefore, a provider may not collect payment from a member, or authorized person acting on behalf of the member, for copays required by other health insurance sources. Instead, the provider should collect from the member **only** the Medicaid or BadgerCare Plus copay amount indicated on the member's remittance information.

Topic #224

Situations When Member Payment Is Allowed

Providers may not collect payment from a member, or authorized person acting on behalf of the member, **except** for the following:

- Required member copays for certain services.
- Other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) payments made to the member.
- Spenddown.
- Charges for a private room in a nursing home if meeting the requirements stated in Wis. Admin. Code § DHS 107.09(4)(k), or in a hospital if meeting the requirements stated in Wis. Admin. Code § DHS 107.08(3)(a)2.
- Noncovered services if certain conditions are met.
- Covered services for which PA (prior authorization) was denied (or an originally requested service for which a PA request was modified) if certain conditions are met. These services are treated as noncovered services.
- Services provided to a member in a limited benefit category when the services are not covered under the limited benefit and

if certain conditions are met.

If a provider inappropriately collects payment from a member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid enrollment.

Copayment

Topic #555

Amounts

Copay amounts for most physician services are determined per procedure code under BadgerCare Plus 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 copays.

Copay amounts for the laboratory and radiology service areas are a fixed amount. Refer to the laboratory and radiology service areas for copay amounts.

Copay Amounts		
E&M (evaluation and management) services (each office visit, hospital admission, or consultation), based on the maximum allowable fee	Up to $10.00	$0.50
	From $10.01 to $25.00	$1.00
	From $25.01 to $50.00	$2.00
	Over $50.00	$3.00
Surgery services	Each	$3.00
Diagnostic services	Each	$2.00
Allergy testing	Per DOS (date of service)	$2.00

Topic #231

Exemptions

Wisconsin Medicaid and BadgerCare Plus Copay Exemptions

According to Wis. Admin. Code § DHS 104.01(12)(a), and 42 C.F.R. § 447.56, providers are prohibited from collecting any copays from these Medicaid and BadgerCare Plus members:

- Children under age 19
- American Indians or Alaskan Natives, regardless of age or income level, who are receiving or have ever received items and services either directly from an Indian health care provider or through referral under contract health services
  - Note: Until further notice, Wisconsin Medicaid and BadgerCare Plus will apply this exemption policy for **all** services regardless of whether a Tribal health care provider or a contracted entity provides the service. Providers may not collect copay from any individual identified in the EVS (Enrollment Verification System) as an American Indian or Alaskan Native.
- Terminally ill individuals receiving hospice care
- Nursing home residents
- Members enrolled in Wisconsin Well Woman Medicaid
- Individuals eligible through EE (Express Enrollment)

These services do not require copays from any member enrolled in Wisconsin Medicaid or BadgerCare Plus:

- Behavioral treatment
- Care coordination services (PNCC (prenatal care coordination) and CCC (child care coordination))
- CRS (Community Recovery Services)
- Crisis intervention services
- CSP (Community support program) services
- CCS (Comprehensive community services)
- Emergency services for medical conditions that meet the prudent layperson standard
  - Note: The prudent layperson standard is defined by 42 C.F.R. § 438.114, and may be expanded to include a psychiatric emergency involving a significant risk or serious harm to oneself or others, a substance abuse emergency in which there is significant risk of serious harm to a member or others or there is likelihood of return to substance abuse without immediate treatment, or emergency dental care, which is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever, or trauma.
- EMTALA (Emergency Medical Treatment and Labor Act)-required medical screening exam and stabilization services
- Family planning services and supplies, including sterilizations
- HealthCheck services
- Home care services (home health, personal care, and PDN (private duty nursing) services)
- Hospice care services
- Independent laboratory services
- Injections
- IOP (intensive outpatient program) services
- Pregnancy-related services
- Preventive services with an A or B rating* from the USPSTF (U.S. Preventive Services Task Force)**, including tobacco cessation services
- SBS (School-based services)
- Substance abuse day treatment services
- Surgical assistance
- Targeted case management services
- Vaccines approved by the Wisconsin DHS (Department of Health Services)

Note: Providers may not impose cost sharing for health-care acquired conditions or other provider-preventable services as defined in federal law under 42 C.F.R. § 447.26(b).

* Providers are required to add CPT (Current Procedural Terminology) modifier 33 to identify USPSTF services that are not specifically identified as preventive in nature. The definition for modifier 33 reads:

> Preventative Services: When the primary purpose of the service is the delivery of an evidence-based service in accordance with a U.S. Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

Since many of the USPSTF recommendations are provided as part of a regular preventive medicine visit, ForwardHealth will not deduct a copay for these services (CPT procedure codes 99381–99387 and 99391–99397).

** The USPSTF recommendations include:

- Screening tests
- Counseling
- Immunizations
- Preventive medications for targeted populations

These services must be provided or recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice.

Topic #233

Limitations

Providers should verify that they are collecting the correct copay for services as some services have monthly or annual copay limits. Providers may not collect member copays in amounts that exceed copay limits.

Monthly Copay Limits

Per the federal limitations on premiums and cost sharing in 42 C.F.R. § 447.56(f), the combined amount of Medicaid premiums and copays a BadgerCare Plus or Medicaid member incurs each month may not exceed 5% of the member's monthly household income. To comply with federal limitations on premiums and cost sharing, ForwardHealth calculates each member's monthly premium and copay limit, which is a maximum allowable copay amount based on monthly income, for individual members. Members within the same household may have different individual copay limits, and children under age 19 are exempt from copays.

Providers must determine whether or not a BadgerCare Plus or Medicaid member is exempt from paying copays or has reached their monthly copay limit by accessing the Enrollment Verification System and receiving the message "No Copay" in response to an enrollment query.

Member Notification

Each member receives a letter in the mail that states their individual monthly copay limit. If a member has a change, such as a change in income or marital status, they will receive a letter with the updated individual monthly copay limit.

When a member reaches their monthly copay limit before the end of the month, they will receive a letter that informs them that they have met their copay limit for that month, and copays will resume on the first day of the following month.

Copay Collection

Once a member meets their individual monthly copay limit, copays will no longer be deducted from the provider's reimbursement. This is true even if subsequent claim adjustments reduce the member's incurred copay amount to below their monthly limit. **Providers may not collect copays from members who have met their individual monthly copay limit.**

Topic #556

Copay Limit for Physician Services

A member's copay for physician services is limited to $30.00 cumulative, per physician or clinic (using a group billing number), per calendar year under BadgerCare Plus and Wisconsin Medicaid.

Topic #237

Refund/Collection

If a provider collects a copay 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 copay amount to the member.

If BadgerCare Plus deducts less copay than the member paid, the provider is required to return or credit the remainder to the member. If BadgerCare Plus deducts more copay than the member paid, the provider may collect the remaining amount from the member.

Topic #239

Requirements

Federal law permits states to charge members a copay for certain covered services. Providers are required to request copays from members. Providers may not deny services to a Wisconsin Medicaid or BadgerCare Plus member who fails to make a copay.

Wis. Stat. § 49.45(18) requires providers to make a reasonable attempt to collect copay from the member unless the provider determines that the cost of collecting the copay exceeds the amount to be collected.

Payer of Last Resort

Topic #242

Instances When Medicaid is Not Payer of Last Resort

Wisconsin Medicaid or BadgerCare Plus are **not** the payer of last resort for members who receive coverage from certain governmental programs, such as:

- Birth to 3
- Crime Victim Compensation Fund
- GA (General Assistance)
- HCBS (Home and Community-Based Services) waiver programs:
  - CLTS (Children's Long-Term Support Program)
  - Family Care
  - Family Care Partnership
  - IRIS (Include, Respect, I Self-Direct)
- IDEA (Individuals with Disabilities Education Act)
- Indian Health Service
- Maternal and Child Health Services
- WCDP (Wisconsin Chronic Disease Program):
  - Adult Cystic Fibrosis
  - Chronic Renal Disease
  - Hemophilia Home Care

Providers should ask members if they have coverage from these other governmental programs.

If the member becomes retroactively enrolled in Wisconsin Medicaid or BadgerCare Plus, providers who have already been reimbursed by one of these government programs may be required to submit the claims to ForwardHealth and refund the payment from the government program.

Topic #251

Other Health Insurance Sources

BadgerCare Plus reimburses only that portion of the allowed cost remaining after a member's other health insurance sources have been exhausted. Other health insurance sources include the following:

- Commercial fee-for-service plans
- Commercial managed care plans
- Medicare supplements (for example, Medigap)
- Medicare
- Medicare Advantage and Medicare Cost plans
- TriCare
- CHAMPVA (Civilian Health and Medical Plan of the Veterans Administration)
- Other governmental benefits

Topic #253

Payer of Last Resort

Except for a few instances, Wisconsin Medicaid or BadgerCare Plus is the payer of last resort for any covered services. Therefore, the provider is required to make a reasonable effort to exhaust all other existing health insurance sources before submitting claims to ForwardHealth or to a state-contracted MCO (managed care organization).

Topic #255

Primary and Secondary Payers

The terms primary payer and secondary payer indicate the relative order in which insurance sources are responsible for paying claims.

In general, commercial health insurance is primary to Medicare, and Medicare is primary to Wisconsin Medicaid and BadgerCare Plus. Therefore, Wisconsin Medicaid and BadgerCare Plus are secondary to Medicare, and Medicare is secondary to commercial health insurance.

Reimbursement Not Available

Topic #693

Reimbursement Not Available

Wisconsin Medicaid may deny or recoup payment for covered services that fail to meet program requirements. Medicaid reimbursement is also not available for noncovered services.

Physician Services Providers

Physician services providers may not receive Medicaid reimbursement for services mentioned in Wis. Admin. Code § DHS 107.06(5).

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 order.
- Dispensing DME (durable medical equipment).
- Mental health and substance abuse services. (Refer to the Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults service area for information regarding enrollment and covered services for these services.)
- Services provided to nursing home residents or hospital inpatients when they are included in the calculation of the daily rates for a nursing home or hospital.

Topic #695

Reimbursement Not Available Through a Factor

BadgerCare Plus will not reimburse providers through a factor, either directly or by virtue of a power of attorney given to the factor by the provider. A factor is an organization (for example, a collection agency) or person who advances money to a provider for the purchase or transferal of the provider's accounts receivable. The term "factor" does not include business representatives, such as billing services, clearinghouses, or accounting firms, which render statements and receive payments in the name of the provider.

Topic #51

Services Not Separately Reimbursable

If reimbursement for a service is included in the reimbursement for the primary procedure or service, it is not separately reimbursable. For example, routine venipuncture is not separately reimbursable, but it is included in the reimbursement for the laboratory procedure or the laboratory test preparation and handling fee. Also, DME (durable medical equipment) delivery charges are included in the reimbursement for DME items.

Resources

9

Archive Date:10/01/2026

Resources:Contact Information

Topic #476

Member Services

Providers should refer ForwardHealth members with questions to Member Services. The telephone number for Member Services is for member use only.

Topic #473

Professional Field Representatives

Professional field representatives, also known as field representatives, are available to assist providers with complex billing and claims processing questions. Field representatives are located throughout the state to offer detailed assistance to all ForwardHealth providers and all ForwardHealth programs.

The field representatives are assigned to specific regions of the state. Most professional field representatives can address inquiries for all provider types. However, certain dedicated professional field representatives are assigned to the following:

- Adult long-term care
- Dental providers
- Milwaukee County
- PNCC (Prenatal care coordination) and CCC (child care coordination)
- WWWP (Wisconsin Well Woman Program)

Provider Education

The field representatives' primary focus is provider education. They provide information on ForwardHealth programs and topics in the following ways:

- Conducting provider training sessions throughout the state
- Providing training and information for newly enrolled providers and/or new staff
- Participating in professional association meetings

Providers may also contact the field representatives if there is a specific topic, or topics, on which they would like to have an individualized training session. This could include topics such as use of the ForwardHealth Portal (information about claims, enrollment verification, and PA (prior authorization) requests on the Portal). Refer to the Providers Trainings page for the latest information on training opportunities.

Additional Inquiries

Providers are encouraged to initially obtain information through the Portal, WiCall, and Provider Services. If these attempts are not successful, field representatives may be contacted for the following types of inquiries:

- Claims, including discrepancies regarding enrollment verification and claim processing
- PES (Provider Electronic Solutions) claims submission software
- Claims processing problems that have not been resolved through other channels (for example, phone or written

correspondence)
- Referrals by a Provider Services phone correspondent
- Complex issues that require extensive explanation

At times, professional field representatives work outside their offices to provide on-site service; therefore, providers should be prepared to leave a complete message when contacting field representatives, including all pertinent information related to the inquiry. Member inquiries should not be directed to field representatives. Providers should refer members to Member Services.

If contacting a field representative by email, providers should ensure that no individually identifiable health information, known as PHI (protected health information), is included in the message. Discuss the appropriate method of sending emails with your assigned field representative to ensure secure transmission of information.

Providers or their representatives should have the following information ready when they contact their professional field representative:

- Name or alternate contact
- County and city where services are provided
- Name of facility or provider whom they are representing
- NPI (National Provider Identifier) or provider number
- Phone number, including area code
- A concise statement outlining concern
- Days and times when available

For questions about a specific claim, providers should also include the following information:

- Claim number
- DOS (date of service)

Topic #474

Provider Services

Providers should call Provider Services to answer enrollment, policy, and billing questions. Members should call Member Services for information. Members should **not** be referred to Provider Services.

The Provider Services Call Center provides service-specific assistance to Medicaid, BadgerCare Plus, WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program) providers.

Ways Provider Services Can Help

The Provider Services Call Center is organized to include program-specific and service-specific assistance to providers. The Provider Services Call Center supplements the ForwardHealth Portal and WiCall by providing information on the following:

- Billing and claim submission
- Provider enrollment
- Member enrollment
- COB (coordination of benefits) (for example, verifying a member's other health insurance coverage)
- Assistance with completing forms
- Assistance with remittance information and claim denials
- Policy clarification
- PA (prior authorization) status
- Claim status

- Verifying covered services

Information to Have Ready

When contacting or transferring from WiCall to the call center, callers will be prompted to enter their NPI (National Provider Identifier) or provider ID. Additionally, to facilitate service, providers are recommended to have all pertinent information related to their inquiry on hand when contacting the call center, including:

- Provider name and NPI or provider ID
- Member name and ID
- Claim ICN (internal control number)
- PA number
- DOS (date of service)
- Amount billed
- RA (Remittance Advice)
- Procedure code of the service in question
- Reference to any provider publications that address the inquiry

Call Center Representatives

The ForwardHealth call center representatives are organized to respond to phone calls from providers. Representatives offer assistance and answer inquiries specific to the program (for example, Medicaid, WCDP, or WWWP) or to the service area (for example, pharmacy services, hospital services) in which they are designated.

In addition to trained call center representatives, Provider Services employs an automated tool for assisting callers. The virtual agent is available 24 hours a day, seven days a week to answer questions that do not require a call center representative, such as inquiries related to:

- Claim status
- PA status
- Provider payment status
- Member enrollment verification

Walk-in Appointments

Walk-in appointments offer face-to-face assistance for providers at the Provider Services office. Providers must schedule an appointment in advance by contacting Provider Services at 800-947-9627. Appointments for in-person provider assistance are available Monday through Friday, 7:30 a.m. – 4 p.m. (Central time), except for state-observed holidays. Providers without an appointment may not receive in-person assistance and may have to schedule an appointment for a later date.

Written Inquiries

Providers may contact Provider Services through the Portal by selecting the Contact Us link. Provider Services will respond to the inquiry by the preferred method of response indicated within five business days. All information is transmitted via a secure connection to protect personal health information.

Providers may submit written inquiries to ForwardHealth by mail using the Written Correspondence Inquiry (F-01170 (07/2012)) form. The Written Correspondence Inquiry form may be photocopied or downloaded via a link from the Portal. Written correspondence should be sent to the following address:

ForwardHealth

Provider Services Written Correspondence
313 Blettner Blvd
Madison WI 53784

Providers are encouraged to use the other resources before mailing a written request to ForwardHealth. Provider Services will respond to written inquiries in writing unless otherwise specified.

Topic #4456

Resources Reference Guide

The Provider Services and Resources Reference Guide lists services and resources available to providers and members with contact information and hours of availability.

ForwardHealth Portal	**www.forwardhealth.wi.gov/**	**24 hours a day, seven days a week**
Public and secure access to ForwardHealth information with direct link to contact Provider Services for up-to-date access to ForwardHealth programs information, including publications, fee schedules, and forms.		
WiCall Automated Voice Response System	**800-947-3544**	**24 hours a day, seven days a week**
WiCall, the ForwardHealth AVR (Automated Voice Response) system, provides responses to the following inquiries: - Checkwrite - Claim status - PA (prior authorization) - Member enrollment		
ForwardHealth Provider Services Call Center	**800-947-9627**	**Call center representatives: Monday – Friday, 7 a.m. – 6 p.m. (Central time)* Virtual agent: 24 hours a day, seven days a week**
To assist providers in the following programs: - BadgerCare Plus - Medicaid - SeniorCare - Family Care - Family Care Partnership - IRIS (Include, Respect, I Self-Direct) - PACE (Program of All-Inclusive Care for the Elderly) - HDAP (Wisconsin HIV Drug Assistance Program) - WCDP (Wisconsin Chronic Disease Program) - Wisconsin Medicaid and BadgerCare Plus Managed Care Programs - Wisconsin Well Woman Medicaid		

- WWWP (Wisconsin Well Woman Program)

ForwardHealth Portal Helpdesk	**866-908-1363**	**Monday – Friday, 8:30 a.m. – 4:30 p.m. (Central time)***
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal accounts, registrations, passwords, and submissions through the Portal.		
Electronic Data Interchange Helpdesk	**866-416-4979**	**Monday – Friday, 8:30 a.m. – 4:30 p.m. (Central time)***
For providers, including trading partners, billing services, and clearinghouses with technical questions about the following: - Electronic transactions - Companion documents - PES (Provider Electronic Solutions) software		
Managed Care Provider Appeals	**800-760-0001, Option 1**	**Monday – Friday, 7 a.m. – 6 p.m. (Central time)***
To assist BadgerCare Plus/Medicaid SSI (Supplemental Security Income) HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) providers with questions regarding their appeal status and other general managed care provider appeal information.		
Managed Care Ombudsman Program	**800-760-0001**	**Monday – Friday, 7 a.m. – 6 p.m. (Central time)***
To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.		
Member Services	**800-362-3002**	**Monday – Friday, 8 a.m. – 6 p.m. (Central time)***
To assist ForwardHealth members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		
Wisconsin HIV Drug Assistance Program	**800-991-5532**	**Monday – Friday, 8 a.m. – 4:30 p.m. (Central time)***
To assist HDAP providers and members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		

*With the exception of state-observed holidays.

Electronic Data Interchange

Topic #459

Companion Guides and NCPDP Version D.0 Payer Sheet

Companion guides and the NCPDP (National Council for Prescription Drug Programs) version D.0 payer sheet are available for download on the ForwardHealth Portal.

Purpose of Companion Guides

ForwardHealth companion guides and payer sheet provide trading partners with useful technical information on ForwardHealth's standards for nationally recognized electronic transactions.

The information in companion guides and payer sheet applies to BadgerCare Plus, Medicaid, SeniorCare, HDAP (Wisconsin HIV Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program). Companion guides and payer sheet are intended for information technology and systems staff who code billing systems or software.

The companion guides and payer sheet complement the federal HIPAA (Health Insurance Portability and Accountability Act of 1996) implementation guides and highlight information that trading partners need to successfully exchange electronic transactions with ForwardHealth, including general topics such as the following:

- Methods of exchanging electronic information (for example, exchange interfaces, transaction administration, and data preparation)
- Instructions for constructing the technical component of submitting or receiving electronic transactions (for example, claims, RA (Remittance Advice), and enrollment inquiries)

Companion guides and payer sheet do **not** include program requirements, but help those who create the electronic formats for electronic data exchange.

Companion guides and payer sheet cover the following specific subjects:

- Getting started (for example, identification information, testing, and exchange preparation)
- Transaction administration (for example, tracking claims submissions, contacting the EDI (Electronic Data Interchange) Helpdesk)
- Transaction formats

Revisions to Companion Guides and Payer Sheet

Companion guides and payer sheet may be updated as a result of changes to federal requirements. When this occurs, ForwardHealth will do the following:

- Post the revised companion guides and payer sheet on the ForwardHealth Portal.
- Post a message on the banner page of the RA.
- Send an email to trading partners.

Trading partners are encouraged to periodically check for revised companion guides and payer sheet on the Portal. If trading

partners do not follow the revisions identified in the companion guides or payer sheet, transactions may not process successfully (for example, claims may deny or process incorrectly).

A change summary located at the end of the revised companion guide lists the changes that have been made. The date on the companion guide reflects the date the revised companion guide was posted to the Portal. In addition, the version number located in the footer of the first page is changed with each revision.

Revisions to the payer sheet are listed in Appendix A. The date on the payer sheet reflects the date the revised payer sheet was posted to the Portal.

Topic #460

Data Exchange Methods

The following data exchange methods are supported by the EDI (Electronic Data Interchange) Helpdesk:

- Remote access server dial-up, using a personal computer with a modem, browser, and encryption software
- Secure web, using an internet service provider and a personal computer with a modem, browser, and encryption software
- Real-time, by which trading partners exchange the NCPDP (National Council for Prescription Drug Programs) D.0, 270/271 (270/271 Eligibility & Benefit Inquiry and Response), 276/277 (276/277 Health Care Claim Status Request and Response), or 278 (278 Health Care Services Review — Request for Review and Response) transactions via an approved clearinghouse

The EDI Helpdesk supports the exchange of the transactions for BadgerCare Plus, Medicaid, SeniorCare, HDAP (Wisconsin HIV Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program).

Topic #461

Electronic Data Interchange Helpdesk

The EDI (Electronic Data Interchange) Helpdesk assists anyone interested in becoming a trading partner with getting started and provides ongoing support pertaining to electronic transactions. Providers, billing services, and clearinghouses are encouraged to contact the EDI Helpdesk for test packets and/or technical questions.

Providers with policy questions should call Provider Services.

Topic #462

Electronic Transactions

HIPAA (Health Insurance Portability and Accountability Act of 1996) ASC (Accredited Standards Committee) X12 Version 5010 Companion Guides and the NCPDP (National Council for Prescription Drug Programs) Version D.0 Payer Sheet are available for download on the HIPAA Version 5010 Companion Guides and NCPDP Version D.0 Payer Sheet page of the ForwardHealth Portal.

Trading partners may submit claims and adjustment requests, inquire about member enrollment, claim status, and ForwardHealth payment advice by exchanging electronic transactions.

Through the EDI (Electronic Data Interchange) Helpdesk, trading partners may exchange the following electronic transactions:

- 270/271 (270/271 Eligibility & Benefit Inquiry and Response): The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.
- 276/277 (276/277 Health Care Claim Status Request and Response): The 276 is the electronic transaction for checking claim status. The 277 is received in response.
- 278 (278 Health Care Services Review — Request for Review and Response): The electronic transaction for health care service PA (prior authorization) requests.
- 835 (835 Health Care Claim Payment/Advice): The electronic transaction for receiving remittance information.
- 837 (837 Health Care Claim): The electronic transaction for submitting claims and adjustment requests.
- 999 (999 Acknowledgment for Health Care Insurance): The electronic transaction for reporting whether a transaction is accepted or rejected.
- TA1 interChange Acknowledgment: The electronic transaction for reporting a transaction that is rejected for interChange-level errors.
- NCPDP D.0 Telecommunication Standard for Retail Pharmacy claims: The real-time POS (Point-of-Sale) electronic transaction for submitting pharmacy claims.

Topic #463

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. PES (Provider Electronic Solutions) software allows providers to submit 837 (837 Health Care Claim) transactions and download the 999 (999 Acknowledgment for Health Care Insurance) and the 835 (835 Health Care Claim Payment/Advice) transactions. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Topic #464

Trading Partner Profile

A Trading Partner Profile must be completed and signed for each billing provider number that will be used to exchange electronic transactions.

In addition, billing providers who do not use a third party to exchange electronic transactions, billing services, and clearinghouses are required to complete a Trading Partner Profile.

To determine whether a Trading Partner Profile is required, providers should refer to the following:

- Billing providers who do not use a third party to exchange electronic transactions, including providers who use the PES (Provider Electronic Solutions) software, are required to complete the Trading Partner Profile.
- Billing providers who use a third party (billing services and clearinghouses) to exchange electronic transactions are required to submit a Trading Partner Profile.
- Billing services and clearinghouses, including those that use PES software, that are authorized by providers to exchange electronic transactions on a provider's behalf, are required to submit a Trading Partner Profile.

Providers who change billing services and clearinghouses or become a trading partner should keep their information updated by contacting the EDI (Electronic Data Interchange) Helpdesk.

Topic #465

Trading Partners

ForwardHealth exchanges nationally recognized electronic transactions with trading partners. A trading partner is defined as a covered entity that exchanges electronic health care transactions. The following covered entities are considered trading partners:

- Providers who exchange electronic transactions directly with ForwardHealth
- Billing services and clearinghouses that exchange electronic transactions directly with ForwardHealth on behalf of a billing provider

Enrollment Verification

Topic #256

270/271 Transactions

The 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response) transactions allow for batch enrollment verification, including information for the current benefit month or for any date of eligibility the member has on file, through a secure internet connection. The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.

For those providers who are federally required to have an NPI (National Provider Identifier), an NPI is required on the 270/271 transactions. The NPI indicated on the 270 is verified to ensure it is associated with a valid enrollment on file with ForwardHealth. The 271 response will report the NPI that was indicated on the 270.

For those providers exempt from NPI, a provider ID is required on the 270/271 transactions. The provider ID indicated on the 270 is verified to ensure it is associated with a valid enrollment on file with ForwardHealth. The 271 response will report the provider ID that was indicated on the 270.

Topic #469

An Overview

Providers should always verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Each enrollment verification method allows providers to verify the following prior to services being rendered:

- A member's enrollment in a ForwardHealth program(s)
- State-contracted MCO (managed care organization) enrollment
- Medicare enrollment
- Limited benefits categories
- Any other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) coverage
- Exemption from copays for BadgerCare Plus members

Topic #259

Commercial Enrollment Verification Vendors

ForwardHealth has agreements with several commercial enrollment verification vendors to offer enrollment verification technology to ForwardHealth providers. Commercial enrollment verification vendors have up-to-date access to the ForwardHealth enrollment files to ensure that providers have access to the most current enrollment information. Providers may access Wisconsin's EVS (Enrollment Verification System) to verify member enrollment through one or more of the following methods available from commercial enrollment verification vendors:

- Magnetic stripe card readers
- Personal computer software
- Internet

Vendors sell magnetic stripe card readers, personal computer software, internet access, and other services. They also provide ongoing maintenance, operations, and upgrades of their systems. Providers are responsible for the costs of using these enrollment verification methods.

Note: Providers are **not** required to purchase services from a commercial enrollment verification vendor. For more information on other ways to verify member enrollment or for questions about ForwardHealth identification cards, contact Provider Services.

The real-time enrollment verification methods allow providers to print a paper copy of the member's enrollment information, including a transaction number, for their records. Providers should retain this number or the printout as proof that an inquiry was made.

Magnetic Stripe Card Readers

The magnetic stripe card readers resemble credit card readers. Some ForwardHealth identification cards have a magnetic stripe and signature panel on the back, and a unique, 16-digit card number on the front. The 16-digit card number is valid only for use with a magnetic card reader.

Providers receive current member enrollment information after passing the ForwardHealth card through the reader or entering the member identification number or card number into a keypad and entering the DOS (date of service) about which they are inquiring.

Personal Computer Software

Personal computer software can be integrated into a provider's current computer system by using a modem and can access the same information as the magnetic stripe card readers.

Internet Access

Some enrollment verification vendors provide real-time access to enrollment from the EVS through the internet.

Topic #4903

Copay Information

No Copay

If a member is enrolled in BadgerCare Plus or Wisconsin Medicaid and is exempt from paying copays for services, providers will receive the following response to an enrollment query from all methods of enrollment verification:

- The name of the benefit plan
- The member's enrollment dates
- The message, No Copay

If a member is enrolled in BadgerCare Plus, Wisconsin Medicaid, or SeniorCare and is required to pay a copay, the provider will be given the name of the benefit plan in which the member is enrolled and the member's enrollment dates for the benefit plan only.

Copay

If a member is enrolled in BadgerCare Plus, Wisconsin Medicaid, or SeniorCare and is required to pay a copay, providers will receive the following response to an enrollment query from all methods of enrollment verification:

- The name of the benefit plan
- The member's enrollment dates

Non-Emergent Copay

If a member is enrolled in BadgerCare Plus and is eligible for the $8 non-emergent copay, providers will receive the following response to an enrollment query from all methods of enrollment verification:

- The name of the benefit plan
- The member's enrollment dates
- The message, Member Eligible for Non-Emergent Copay or Eligible for Non-Emergent Copay

The messages Member Eligible for Non-Emergent Copay and Eligible for Non-Emergent Copay indicate that a member is a BadgerCare Plus childless adult, and they are eligible for the copay if they do not meet the prudent layperson standard and seek and receive additional post-stabilization care in the emergency department after being informed of the $8 copay and availability of alternative providers with lesser or no cost share.

Topic #264

Enrollment Verification System

Member enrollment issues are the primary reason claims are denied. To reduce claim denials, providers should **always** verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Providers may want to verify the member's enrollment a second time before submitting a claim to find out whether the member's enrollment information has changed since the appointment.

Providers can access Wisconsin's EVS (Enrollment Verification System) to receive the most current enrollment information through the following methods:

- ForwardHealth Portal
- WiCall, Wisconsin's AVR (Automated Voice Response) system
- Commercial enrollment verification vendors
- 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Response) transactions
- Provider Services

Providers cannot charge a member, or authorized person acting on behalf of the member, for verifying their enrollment.

The EVS does not indicate other government programs that are secondary to Wisconsin Medicaid.

Topic #4901

Enrollment Verification on the Portal

The secure ForwardHealth Portal offers real-time member enrollment verification for all ForwardHealth programs. Providers will be able to use this tool to determine:

- The benefit plan(s) in which the member is enrolled.
- If the member is enrolled in a state-contracted managed care program (for Medicaid and BadgerCare Plus members).

- If the member has any other coverage, such as Medicare or commercial health insurance.
- If the member is exempted from copays (BadgerCare Plus and Medicaid members only).

To access enrollment verification via the ForwardHealth Portal, providers will need to do the following:

- Go to the ForwardHealth Portal.
- Establish a provider account.
- Log into the secure Portal.
- Click on the menu item for enrollment verification.

Providers will receive a unique transaction number for each enrollment verification inquiry. Providers may access a history of their enrollment inquiries using the Portal, which will list the date the inquiry was made and the enrollment information that was given on the date that the inquiry was made. For a more permanent record of inquiries, providers are advised to use the print screen function to save a paper copy of enrollment verification inquiries for their records or document the transaction number at the beginning of the response, for tracking or research purposes. This feature allows providers to access enrollment verification history when researching claim denials due to enrollment issues.

The Provider Portal is available 24 hours a day, seven days a week.

Topic #4900

Entering Dates of Service

Enrollment information is provided based on a From DOS (date of service) and a To DOS that the provider enters when making the enrollment inquiry. For enrollment inquires, a From DOS is the earliest date for which the provider is requesting enrollment information and the To DOS is the latest date for which the provider is requesting enrollment information.

Providers should use the following guidelines for entering DOS when verifying enrollment for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, or WCDP (Wisconsin Chronic Disease Program) members:

- The From DOS is the earliest date the provider requires enrollment information.
- The To DOS must be within 365 days of the From DOS.
- If the date of the request is prior to the 20th of the current month, then providers may enter a From DOS and To DOS up to the end of the current calendar month.
- If the date of the request is on or after the 20th of the current month, then providers may enter a From DOS and To DOS up to the end of the following calendar month.

For example, if the date of the request was November 15, 2008, the provider could request dates up to and including November 30, 2008. If the date of the request was November 25, 2008, the provider could request dates up to and including December 31, 2008.

Topic #265

Member Forgets ForwardHealth Identification Card

Even if a member does not present a ForwardHealth identification card, a provider can use Wisconsin's EVS (Enrollment Verification System) to verify enrollment; otherwise, the provider may choose not to provide the service(s) until a member brings in a ForwardHealth card or displays a digital ForwardHealth Card on the MyACCESS app.

A provider may use a combination of the member's name, date of birth, ForwardHealth identification number, or SSN (Social Security number) with a 0 at the end to access enrollment information through the EVS.

A provider may call Provider Services with the member's full name and date of birth to obtain the member's enrollment information if the member's identification number or SSN is not known.

Topic #4899

Member Identification Card Does Not Guarantee Enrollment

Most members receive a member identification card, but possession of a program identification card does not guarantee enrollment. Periodically, members may become ineligible for enrollment, only to re-enroll at a later date. Members are told to keep their cards even though they may have gaps in enrollment periods. It is possible that a member will present a card when they are not enrolled; therefore, it is essential that providers verify enrollment before providing services. To reduce claim denials, it is important that providers verify the following information prior to each DOS (date of service) that services are provided:

- If a member is enrolled in any ForwardHealth program, including benefit plan limitations.
- If a member is enrolled in a managed care organization.
- If a member is in primary provider lock-in status.
- If a member has Medicare or other insurance coverage.

Topic #4898

Responses Are Based on Financial Payer

When making an enrollment inquiry through Wisconsin's EVS (Enrollment Verification System), the returned response will provide information on the member's enrollment in benefit plans based on financial payers.

There are three financial payers under ForwardHealth:

- Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and SeniorCare).
- WCDP (Wisconsin Chronic Disease Program).
- WWWP (Wisconsin Well Woman Program).

Within each financial payer are benefit plans. Each member is enrolled under at least one of the three financial payers, and under each financial payer, is enrolled in at least one benefit plan. An individual member may be enrolled under more than one financial payer. (For instance, a member with chronic renal disease may have health care coverage under BadgerCare Plus and the WCDP chronic renal disease program. The member is enrolled under two financial payers, Medicaid and WCDP.) Alternatively, a member may have multiple benefits under a single financial payer. (For example, a member may be covered by Tuberculosis-Related Medicaid and Family Planning Only Services at the same time, both of which are administered by Medicaid.)

Forms

Topic #767

An Overview

ForwardHealth requires providers to use a variety of forms for PA (prior authorization), claims processing, and documenting special circumstances.

Topic #470

Fillable Forms

Most forms may be obtained from the Forms page of the ForwardHealth Portal.

Forms on the Portal are available as fillable PDF files, which can be viewed with Adobe Reader computer software. Providers may also complete and print fillable PDF files using Adobe Reader.

To complete a fillable PDF, follow these steps:

- Select a specific form.
- Save the form to the computer.
- Use the Tab key to move from field to field.

Note: The Portal provides instructions on how to obtain Adobe Reader at no charge from the Adobe website. Adobe Reader only allows providers to view and print completed PDFs. It does not allow users to save completed fillable PDFs to their computer; however, if Adobe Acrobat is purchased, providers may save completed PDFs to their computer. Refer to the Adobe website for more information about fillable PDFs.

Selected forms are also available in fillable Microsoft Word format on the Portal. The fillable Microsoft Word format allows providers to complete and print the form using Microsoft Word. To complete a fillable Microsoft Word form, follow these steps:

- Select a specific form.
- Save the form to the computer.
- Use the Tab key to move from field to field.

Note: Providers may save fillable Microsoft Word documents to their computer by choosing Save As from the File menu, creating a file name, and selecting Save on their desktop.

Topic #766

Telephone or Mail Requests

Providers who do not have internet access or who need forms that are not available on the ForwardHealth Portal may obtain them by doing either of the following:

- Requesting a paper copy of the form by calling Provider Services. Questions about forms may also be directed to Provider

Services.

- Submitting a written request and mailing it to ForwardHealth. Include a return address, the name of the form, and the form number and send the request to the following address:

    ForwardHealth
    Form Reorder
    313 Blettner Blvd
    Madison WI 53784

Portal

Topic #4743

Acute and Primary Managed Care Portal

Information and Functions Through the Portal

The acute and primary managed care area of the ForwardHealth Portal allows state-contracted HMOs to conduct business with ForwardHealth. The public HMO page offers easy access to key HMO information and web tools. A login is required to access the secure area of the Portal to submit or retrieve account and member information that may be sensitive.

The following information is available through the Portal:

- Listing of all Medicaid-enrolled providers
- Coordination of Benefits Extract/Insurance Carrier Master List information updated quarterly
- Data Warehouse, which is linked from the Portal to Business Objects. The Business Objects function allows for access to MCO (managed care organization) data for long-term care MCOs.
- Electronic messages
- Enrollment verification by entering a member ID or SSN (Social Security number) with date of birth and a From DOS (date of service) and a To DOS range. A transaction number is assigned to track the request.
- Member search function for retrieving member information such as medical status codes and managed care and Medicare information
- Provider search function for retrieving provider information such as the address, phone number, provider ID, taxonomy code (if applicable), and provider type and specialty
- HealthCheck information
- MCO contact information
- Technical contact information (Entries may be added via the Portal.)

Topic #4904

Claims and Adjustments Using the ForwardHealth Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, copy claims, and determine what claims are in pay status on the ForwardHealth Portal. Providers have the ability to search for and view the status of all their finalized claims, regardless of how they were submitted (for example, paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim through DDE (Direct Data Entry) through the secure Portal.

Topic #8524

Conducting Revalidation Via the ForwardHealth Portal

Providers can conduct revalidation online via a secure revalidation area of the ForwardHealth Portal.

Topic #4345

Creating a Provider Account

Each provider needs to designate one individual as an administrator of the ForwardHealth Portal account. This user establishes the administrative account once their PIN (personal identification number) is received. The administrative user is responsible for this provider account and can add accounts for other users (clerks) within their organization and assign security roles to clerks that have been established. To establish an administrative account after receiving a PIN, the administrative user is required to follow these steps:

1. Go to the ForwardHealth Portal.
2. Click the **Providers** button.
3. Click **Logging in for the first time?**.
4. Enter the Login ID and PIN. The Login ID is the provider's NPI (National Provider Identifier) or provider number.
5. Click **Setup Account**.
6. At the Account Setup screen, enter the user's information in the required fields. Enter a backup user's information in the required fields.
7. Read the security agreement and click the checkbox to indicate agreement with its contents.
8. Click **Submit** when complete.

Once in the secure Provider area of the Portal, the provider may conduct business online with ForwardHealth via a secure connection. Providers may also perform the following administrative functions from the Provider area of the Portal:

- Establish accounts and define access levels for clerks
- Add other organizations to the account
- Switch organizations

Refer to the Account User Guide on the User Guides page of the Portal for more detailed instructions on performing these functions.

Topic #16737

Demographic Maintenance Tool

The demographic maintenance tool allows providers to update information online that they are required to keep current with ForwardHealth. To access the demographic maintenance tool, providers need a ForwardHealth Portal account. After logging into their Portal account, providers should select the Demographic Maintenance link located in the Home Page box on the right side of the secure Provider home page.

Note: The Demographic Maintenance link will only display for administrative accounts or for clerk accounts that have been assigned the Demographic Maintenance role. The Account User Guide provides specific information about assigning roles.

The demographic maintenance tool contains general panels which are available to all or most providers as well as specific panels which are only available to certain provider types and specialties. The Demographic Maintenance Tool User Guide provides further information about general and provider-specific panels.

Uploading Supporting Documentation

Providers can upload enrollment-related supporting documentation (for example, licenses, certifications) using the demographic maintenance tool. Documents in the following formats can be uploaded:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg)
- PDF (Portable Document Format) (.pdf)

To avoid delays in processing, ForwardHealth strongly encourages providers to upload their documents.

Submitting Information

After making **all** their changes, providers are required to submit their information in order to save it. After submitting information, providers will receive one of the following messages:

- Your information was **updated** successfully. This message indicates that providers' files were immediately updated with the changed information.
- Your information was **uploaded** successfully. This message indicates that ForwardHealth needs to verify the information before providers' files can be updated. Additionally, an Application Submitted panel will display and indicate next steps.

Verification

ForwardHealth will verify changes within 10 business days of submission. If the changes can be verified, ForwardHealth will update providers' files. In some cases, providers may receive a Change Notification letter indicating what information ForwardHealth updated. Providers should carefully review the Provider File Information Change Summary included with the letter to verify the accuracy of the changes. If any of the changes are inaccurate, providers can correct the information using the demographic maintenance tool. Providers may contact Provider Services if they have questions regarding the letter.

Regardless of whether or not providers are notified that their provider files were updated, changed information is not considered approved until 10 business days after the information was changed. If the changes cannot be verified within 10 business days, ForwardHealth will notify providers by mail that their provider files were not updated, and providers will need to make corrections using the demographic maintenance tool.

Topic #4340

Designating a Trading Partner to Receive 835 Health Care Claim Payment/Advice Transactions

Providers must designate a trading partner to receive their 835 (835 Health Care Claim Payment/Advice) transaction for ForwardHealth interChange.

Providers who wish to submit their 835 designation via the Portal are required to create and establish a provider account to have access to the secure area of the Portal.

To designate a trading partner to receive 835 transactions, providers must first complete the following steps:

1. Access the Portal and log into their secure account by clicking the Provider link/button.
2. Click on the Designate 835 Receiver link on the right-hand side of the secure home page.
3. Enter the identification number of the trading partner that is to receive the 835 in the Trading Partner ID field.
4. Click Save.

Providers who are unable to use the Portal to designate a trading partner to receive 835 transactions may call the EDI (Electronic Data Interchange) Helpdesk or submit a paper (Trading Partner 835 Designation, F-13393 (07/12)) form.

Topic #5088

Enrollment Verification

The secure ForwardHealth Portal offers real time member enrollment verification for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled
- Whether or not the member is enrolled in a state-contracted MCO (managed care organization)
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance
- Whether or not the member is enrolled in the Pharmacy Services Lock-In Program and the member's Lock-In pharmacy, primary care provider, and referral providers (if applicable)

Using the Portal to check enrollment may be more effective than calling WiCall or the EVS (Enrollment Verification System) (although both are available).

Providers are assigned a unique enrollment verification number for each inquiry. Providers can also use the print screen function to print a paper copy of enrollment verification inquiries for their records.

Topic #4338

ForwardHealth Portal

Providers, members, trading partners, managed care programs, and partners have access to public **and** secure information through the ForwardHealth Portal.

The Portal has the following areas:

- Providers (public and secure)
- Trading Partners
- Members
- MCO (managed care organization)
- Partners

The secure Portal allows providers to conduct business and exchange electronic transactions with ForwardHealth. The public Portal contains general information accessible to all users. Members can access general health care program information and apply for benefits online.

Topic #4441

ForwardHealth Portal Helpdesk

Providers and trading partners may call the ForwardHealth Portal Helpdesk with technical questions on Portal functions, including their Portal accounts, registrations, passwords, and submissions through the Portal.

Topic #4581

HealthCheck Information Available Through the ForwardHealth Portal

HealthCheck providers can access outreach reports and view screening history, the periodicity schedule, and the WIR (Wisconsin Immunization Registry) through the ForwardHealth Portal.

HealthCheck Agency Portal Outreach Reports

HealthCheck agency outreach reports are available through the secure area of the Portal for agencies with "active" Portal user IDs. HealthCheck outreach agencies receive a notification in their message box when updated monthly and quarterly reports are available. The message gives providers instructions on how to download their files. Notifications in the message box are retained for seven calendar days.

The monthly report, titled "HealthCheck Monthly Screening," is uploaded every 28 days and the quarterly report, titled "HealthCheck Quarterly Eligibility Member," is replaced every 88 days by a new report with updated information.

Paper reports are mailed to providers without a Portal account.

HealthCheck Screening Inquiry

Providers may use the online inquiry function to query a member's HealthCheck screening history by entering one of the following:

- Member ID
- Member's first and last name and date of birth
- Member SSN (Social Security number) and date of birth

Once the member information is entered, the following member information is displayed:

- Member ID
- First and last name
- Date of last HealthCheck screening
- Date of last HealthCheck dental screening
- Date of birth

If the member has additional past HealthCheck medical screenings or HealthCheck dental screenings, the history of the member is displayed in the "Search Results" panel including:

- Previous date(s) of service
- Name(s) of provider(s) that performed past HealthCheck medical or dental screening(s)
- Member age at time of previous HealthCheck medical or dental screening(s)
- Status of the claim(s)

Information about HealthCheck screens reimbursed by fee-for-service or HMOs is available through the HealthCheck screening inquiry.

Note: Providers have 365 days from the date of service to submit a claim, and HMOs have one year to submit encounter data. Therefore, delayed submission of HealthCheck screening information affects the availability of data in the screening query.

Periodicity Schedule

The periodicity schedule lists the frequency and timing of recommended HealthCheck screens. Providers may also access the periodicity schedule via the HealthCheck provider resource page in the Provider area of the Portal.

WIR

A link on the secure HealthCheck page in the Portal connects users to the WIR website to view immunization data. WIR will continue to monitor all vaccination information for children, maintain recommended immunization schedules, record immunizations, track contraindications and reactions, and verify immunization history. Additionally, complete blood lead level testing history and the testing results are available.

Providers may access the WIR website via the Portal or may continue to access the site directly at https://www.dhfswir.org/. Login and password requirements for WIR apply regardless of the link used to reach the website.

Topic #4451

Inquiries to ForwardHealth via the Portal

Providers are able to contact Provider Services through the ForwardHealth Portal by clicking the Contact link and entering the relevant inquiry information, including selecting the preferred method of response (for example, telephone call or email). Provider Services will respond to the inquiry by the preferred method of response indicated within five business days.

Topic #4400

Internet Connection Speed

ForwardHealth recommends providers have an internet connection that will provide an upload speed of at least 768 Kbps and a download speed of at least 128 Kbps in order to efficiently conduct business with ForwardHealth via the Portal.

For PES (Provider Electronic Solutions) users, ForwardHealth recommends an internet connection that will provide a download speed of at least 128 Kbps for downloading PES software and software updates from the Portal.

These download speeds are generally not available through a dial-up connection.

Topic #4351

Logging in to the Provider Area of the Portal

Once an administrative user's or other user's account is set up, they may log in to the Provider area of the ForwardHealth Portal to conduct business. To log in, the user is required to click the Provider link or button, then enter their username and password and click Go in the Login to Secure Site box at the right side of the screen.

If a user has forgotten their username, they can recover their username by choosing from the following options:

- Ask the Portal Helpdesk to do one of the following:
  - Send the Portal account username to the email account on record.
  - Verify the request with the designated account backup.
- Ask the Portal Helpdesk to remove the Portal account's current credentials and create a new account.

Topic #5158

Managed Care Organization Portal Reports

The following reports are generated to MCOs (managed care organizations) through their account on the ForwardHealth MCO

Portal:

- Capitation Payment Listing Report
- Cost Share Report (long-term MCOs only)
- Enrollment Reports

MCOs are required to establish a Portal account in order to receive reports from ForwardHealth.

Capitation Payment Listing Report

The Capitation Payment Listing Report provides payee MCOs with a detailed listing of the members for whom they receive capitation payments. ForwardHealth interChange creates adjustment transaction information weekly and regular capitation transaction information monthly. The weekly batch report includes regular and adjustment capitation transactions. MCOs have the option of receiving both the Capitation Payment Listing Report and the 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transactions.

Initial Enrollment Roster Report

The Initial Enrollment Roster Report is generated according to the annual schedules detailing the number of new and continuing members enrolled in the MCO and those disenrolled before the next enrollment month.

Final Enrollment Roster Report

The Final Enrollment Roster Report is generated the last business day of each month and includes members who have had a change in status since the initial report and new members who were enrolled after the Initial Enrollment Roster Report was generated.

Other Reports

Additional reports are available for BadgerCare Plus HMOs, SSI HMOs, and long-term MCOs. Some are available via the Portal and some in the secure FTP (file transfer protocol).

Topic #4744

Members ForwardHealth Portal

Members can access ForwardHealth information by going to the ForwardHealth Portal. Members can search through a directory of providers by entering a ZIP code, city, or county. Members can also access all member-related ForwardHealth applications and forms. Members can use ACCESS to check availability, apply for benefits, check current benefits, and report any changes.

Topic #4344

Obtaining a Personal Identification Number

To establish an account on the ForwardHealth Portal, providers are required to obtain a PIN (personal identification number). The PIN is a unique, nine-digit number assigned by ForwardHealth interChange for the sole purpose of allowing a provider to establish a Portal account. It is used in conjunction with the provider's login ID. Once the Portal account is established, the provider will be prompted to create a username and password for the account, which will subsequently be used to log in to the Portal.

Note: The PIN used to create the provider's Portal account is not the same PIN used for revalidation. Providers will receive a separate PIN for revalidation.

A provider may need to request more than one PIN if he or she is a provider for more than one program or has more than one type of provider enrollment. A separate PIN will be needed for each provider enrollment. Health care providers will need to supply their NPI (National Provider Identifier) and corresponding taxonomy code when requesting an account. Non-healthcare providers will need to supply their unique provider number.

Providers may request a PIN by following these steps:

1. Go to the Portal.
2. Click the Providers link or button.
3. Click the Request Portal Access link from the Quick Links box on the right side of the screen.
4. At the Request Portal Access screen, enter the following information:
    a. Health care providers are required to enter their NPI and click Search to display a listing of ForwardHealth enrollments. Select the correct enrollment for the account. The taxonomy code, ZIP+4 code, and financial payer for that enrollment will be automatically populated. Enter the SSN (Social Security number) or TIN (Tax Identification Number).
    b. Non-healthcare providers are required to enter their provider number, financial payer, and SSN or TIN. (This option should only be used by non-healthcare providers who are exempt from NPI requirements).

        The financial payer is one of the following:
        - Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and SeniorCare.)
        - SSI (Supplemental Security Income)
        - WCDP (Wisconsin Chronic Disease Program)
        - WWWP (Wisconsin Well Woman Program)

    c. Click **Submit**.
    d. Once the Portal Access Request is successfully completed, ForwardHealth will send a letter with the provider's PIN to the address on file.

Topic #4459

Online Handbook

The Online Handbook gives providers access to all policy and billing information for Wisconsin Medicaid, BadgerCare Plus, HDAP (Wisconsin HIV Drug Assistance Program), and WCDP (Wisconsin Chronic Disease Program). A secure ForwardHealth Portal account is not required to use the Online Handbook, as it is available to all Portal visitors.

Revisions to Online Handbook information are incorporated after policy changes have been issued in ForwardHealth Updates, typically on the policy effective date. The Online Handbook also links to the Communication Home page, which takes users to ForwardHealth Updates, user guides, and other communication pages.

The Online Handbook is designed to sort information based on user-entered criteria, such as program and provider type. It is organized into sections, chapters, and topics. Sections within each handbook may include the following:

- Claims
- Coordination of Benefits
- Covered and Noncovered Services
- Managed Care
- Member Information
- Prior Authorization

- Provider Enrollment and Ongoing Responsibilities
- Reimbursement
- Resources

Each section consists of separate chapters (for example, claims submission, procedure codes), which contain further detailed information in individual topics.

Search Function

The Online Handbook has a search function that allows providers to search for a specific word, phrase, or topic number within a user type, program, service area, or throughout the entire Online Handbook.

Providers can access the search function by following these steps:

1. Go to the Portal.
2. Click **Online Handbooks** under the Policy and Communication heading.
3. Complete the two drop-down selections at the left to narrow the search by program and service area, if applicable. This is not needed if searching the entire Online Handbook.
4. Enter the word, phrase, or topic number you would like to search.
5. Select **Search within the options selected above** or **Search all handbooks, programs and service areas; or Search by Topic Number.**
6. Click **Search**.

Saving Preferences

Providers can select Save Preferences when performing a search (by service area, section, chapter, topic number) and will receive confirmation that their preferences have been saved. This will save the program (for example, BadgerCare Plus and Medicaid) and service area (for example, Anesthesiologist) combinations that are selected from the drop-down menus. The next time the provider accesses the Online Handbook, they will be taken to their default preferences page. The provider can also click the Preferences Home link, which returns the provider to the saved area of the Online Handbook with their default preferences.

ForwardHealth Publications Archive Area

The Handbook Archives page allows providers to view previous versions of the Online Handbook. Providers can access the archive information area by following these steps:

1. Go to the Portal.
2. Click the **Communication Home** link under the Policy and Communication heading.
3. Click the **Online Handbooks** link on the left sidebar menu.
4. Click on the **ForwardHealth Handbook Archives** link at the bottom of the page.

Topic #5089

Other Business Enhancements Available on the Portal

The secure Provider area of the ForwardHealth Portal enables providers to do the following:

- Verify member enrollment.
- View RAs (Remittance Advice).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice).
- Update and maintain provider file information. Providers have the choice to indicate separate addresses for different

business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT (electronic funds transfer).
- Track provider-submitted PA (prior authorization) requests.

Topic #4911

Portal Account Administrators

Portal administrators are responsible for requesting, creating, and managing accounts to access these features for their organization.

There must be one administrator assigned for each Portal account and all users established for that account. The responsibilities of the Portal administrator include:

- Ensuring the security and integrity of all user accounts (clerk administrators and clerks) created and associated with their Portal account.
- Ensuring clerks or clerk administrators are given the appropriate authorizations they need to perform their functions for the provider, trading partner, or MCO (managed care organization).
- Ensuring that clerks or clerk administrator accounts are removed/deleted promptly when the user leaves the organization.
- Ensuring that the transactions submitted are valid and recognized by ForwardHealth.
- Ensuring that all users they establish know and follow security and guidelines as required by HIPAA (Health Insurance Portability Accountability Act of 1996). As Portal administrators establish their Portal account and create accounts for others to access private information, administrators are reminded that all users must comply with HIPAA. The HIPAA privacy and security rules require that the confidentiality, integrity, and availability of PHI (protected health information) are maintained at all times. The HIPAA Privacy Rule provides guidelines governing the disclosure of PHI. The HIPAA Security Rule delineates the security measures to be implemented for the protection of electronic PHI. If Portal administrators have any questions concerning the protection of PHI, visit the Portal for additional information.

Portal administrators have access to all secure functions for their Portal account.

Establish an Administrator Account

All Portal accounts require an administrator account. The administrator is a selected individual who has overall responsibility for management of the account. Therefore, they have complete access to all functions within the specific secure area of their Portal and are permitted to add, remove, and manage other individual roles.

Add Backup Contact Information for Provider Administrator Accounts

Provider administrators must set up a backup contact for their Portal accounts to ensure that requests and changes can be verified as legitimate. Provider administrators will not be able to use the same contact information for both the administrator account and the backup contact.

Topic #4912

Portal Clerk Administrators

A Portal administrator may choose to delegate some of the authority and responsibility for setting up and managing the users within their ForwardHealth Portal account. If so, the Portal administrator may establish a clerk administrator. An administrator or clerk administrator can create, modify, manage, or remove clerks for a Portal account. When a clerk is created, the administrator or clerk administrator must grant permissions to the clerks to ensure they have the appropriate access to the functions they will

perform. A clerk administrator can only grant permissions that they themselves have. For example, if an administrator gives a clerk administrator permission only for enrollment verification, then the clerk administrator can only establish clerks with enrollment verification permissions.

Even if a Portal administrator chooses to create a clerk administrator and delegate the ability to add, modify, and remove users from the same account, the Portal administrator is still responsible for ensuring the integrity and security of the Portal account.

Topic #4913

Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their ForwardHealth Portal account. Clerks may be assigned one or many roles (for example, claims, PA (prior authorization), member enrollment verification). Clerks do not have the ability to establish, modify, or remove other accounts.

Once a clerk account is set up, the clerk account does not have to be established again for a separate Portal account. Clerks can easily be assigned a role for different Portal accounts (for example, different ForwardHealth enrollments). To perform work under a different Portal account for which they have been granted authorization, a clerk can use the switch org function and toggle between the Portal accounts to which they have access. Clerks may be granted different authorization in each Portal account (for example, they may do member enrollment verification for one Portal account and HealthCheck inquires for another).

Topic #4740

Public Area of the Provider Portal

The public Provider area of the ForwardHealth Portal offers a variety of important business features and functions that will assist in daily business activities with ForwardHealth programs.

Interactive Maximum Allowable Fee Schedule

Within the Portal, are maximum allowable fee schedules for most services. Providers can search the interactive maximum allowable fee schedule by a single procedure code, multiple codes, a code range, or by a service area to find the maximum allowable fee. Through the interactive fee schedule, providers also can export their search results for a single code, multiple codes, a code range, or by service area. The downloadable fee schedules, which are updated monthly, are downloadable only by service area as TXT (text) or CSV (comma separated value) files.

ForwardHealth Communications

ForwardHealth Updates announce changes in policy and coverage, PA (prior authorization) requirements, and claim submission requirements. They communicate new initiatives from the Wisconsin DHS (Department of Health Services) or new requirements from the federal CMS (Centers for Medicare & Medicaid Services) and the Wisconsin state legislature.

Updates reflect current policy at the time of publication; this information may change over time and be revised by a subsequent Update. Update information is added to the ForwardHealth Online Handbook after the Update is posted, unless otherwise noted.

Providers should refer to the Online Handbook for current information. The Online Handbook is the source for current ForwardHealth policy and contains provider-specific information for various services and benefits.

Trainings

Providers can register for all scheduled trainings and view online trainings via the Trainings page, which contains an up-to-date calendar of all available training. Additionally, providers can view webcasts of select trainings.

Contacting Provider Services

Providers and other Portal users will have an additional option for contacting Provider Services through the Contact link on the Portal. Providers can enter the relevant inquiry information, including selecting the preferred method of response (for example, a phone call or email) the provider wishes to receive back from Provider Services. Provider Services will respond to the inquiry within five business days. Information will be submitted via a secure connection.

Online Enrollment

Providers can speed up the enrollment process for Medicaid by completing a provider enrollment application via the Portal. Providers can then track their application by entering their ATN (application tracking number) given to them on completion of the application.

Other Resources Available on the Portal

The public Provider area of the Portal also includes the following features:

- A What's New? section for providers that links to the latest information posted to the Provider area of the Portal.
- Home page for the provider. (Providers have administrative control over their Portal homepage and can grant other employees access to specified areas of the Portal, such as claims and PA.)
- Email subscription service for Updates. (Providers can register for email subscription to receive notifications of new provider publications via email. Users are able to select, by program and service area, which publication notifications they would like to receive.)
- A forms library.

Topic #4741

Secure Area of the Provider Portal

Providers can accomplish many processes via the ForwardHealth Portal, including submitting, adjusting, and correcting claims, submitting and amending PA (prior authorization) requests, and verifying enrollment.

Claims and Adjustments Using the Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, and determine what claims are in pay status on the Portal. Providers can search for and view the status of all of their finalized claims, regardless of how they were submitted (for example, paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim via DDE (Direct Data Entry) through the secure Portal.

Submitting PA and Amendment Requests via the Portal

Nearly all service areas can submit PA requests via the Portal. Providers can do the following:

- Correct errors on PA or amendment requests via the Portal, regardless of how the PA request was originally submitted.
- View all recently submitted and finalized PA and amendment requests.

- Save a partially completed PA request and finish completing it at a later time. (Note: providers are required to submit or re-save a PA request within 30 calendar days of the date the PA request was last saved.)
- View all saved PA requests and select any to continue completing or delete.
- View the latest provider review and decision letters.
- Receive messages about PA and amendment requests that have been adjudicated or returned for provider review.

Electronic Communications

The secure Portal contains a two-way message center where providers can send and receive electronic notifications as well as receive links to ForwardHealth provider publications. Providers will be able to send secure messages to select Wisconsin DHS (Department of Health Services) groups/staff by selecting a recipient from a drop-down menu; options in the drop-down menu will differ based on the provider's security role. All new messages will be displayed on the provider's secure Portal messages inbox.

Providers can sign up to receive notifications about the availability of new ForwardHealth messages through email, text, or both. After signing up, the user will receive a verification email to register their device. Once registered, providers will receive notifications by the requested method(s).

Enrollment Verification

The secure Portal offers real-time member enrollment verification for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled.
- Whether or not the member is enrolled in a state-contracted MCO (managed care organization).
- Whether or not the member has other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans), such as Medicare or commercial health insurance.

Using the Portal to check enrollment may be more efficient than calling the AVR (Automated Voice Response) system or the EVS (Enrollment Verification System) (although both are available).

Providers will be assigned a unique enrollment verification number for each inquiry. Providers can also use the print screen function to print a paper copy of enrollment verification inquiries for their records.

Other Business Enhancements Available on the Portal

The secure Provider area of the Portal enables providers to do the following:

- Verify member enrollment.
- View RAs (Remittance Advices).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice) transaction.
- Update and maintain provider file information; providers will have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT (electronic funds transfer).
- Track provider-submitted PA requests.

Topic #4905

Submitting Prior Authorization and Amendment

Requests Via the Portal

Nearly all service areas can submit PA (prior authorization) requests via the ForwardHealth Portal. Providers can do the following:

- Correct errors on PAs or amendment requests via the Portal, regardless of how the PA was originally submitted.
- View all recently submitted and finalized PAs and amendment requests.
- View the latest provider review and decision letters.
- Receive messages about PA and amendment requests that have been adjudicated.
- Request extensions for single episode of treatment for Behavioral Health Services.

Topic #4401

System and Browser Requirements

The following table lists the recommended system and browser requirements for using the ForwardHealth Portal. PES (Provider Electronic Solutions) users should note that the Windows-based requirements noted in the table apply; PES cannot be run on Apple-based systems.

Recommended System Requirements	Recommended Browser Requirements
Windows-Based Systems	
Computer with at least a 500Mhz processor, 256 MB of RAM, and 100MB of free disk space	Chrome v. 73 or higher, Edge v. 19 or higher, Firefox v. 38 or higher
Windows XP or higher operating system	
Apple-Based Systems	
Computer running a PowerPC G4 or Intel processor, 512 MB of RAM, and 150MB of free disk space	Chrome v. 73 or higher, Edge v. 19 or higher, Safari v. 14 or higher, Firefox v. 38 or higher
Mac OS X 10.2 or higher operating system	

Topic #4742

Trading Partner Portal

The following information is available on the public Trading Partners area of the ForwardHealth Portal:

- Trading partner testing packets
- Trading partner profile submission
- PES (Provider Electronic Solutions) software and upgrade information
- EDI (Electronic Data Interchange) companion guides

In the secure Trading Partners area of the Portal, trading partners can exchange electronic transactions with ForwardHealth.

Trading partners using PES should be sure to enter the web logon and web password associated with the ForwardHealth Trading Partner ID that will be used on PES transactions. Prior to submitting transactions through PES, trading partners must also make sure their trading partner account is entered as the Default Provider ID on the Switch Organization page of the secure trading partner account on the Portal.

Training Opportunities

Topic #12757

Training Opportunities

The Provider Relations representatives conduct training sessions in a variety of formats on both program-specific and topic-specific subjects. There is no fee for attending/accessing these training sessions.

On-Site Sessions

On-site training sessions are offered at various locations (for example, hotel conference rooms, provider facilities) throughout the state. These training sessions include general all-provider sessions, service-specific and/or topic-specific sessions, and program-specific (such as WCDP (Wisconsin Chronic Disease Program) or the WWWP (Wisconsin Well Woman Program)) sessions.

Registration is required to attend on-site sessions. Online registration is available on the Trainings page of the Providers area of the Portal.

Online (Real-Time, Web-Based) Sessions

Online (real-time, web-based) training sessions are available and are facilitated through HPE MyRoom. MyRoom sessions are offered on many of the same topics as on-site sessions, but online sessions offer the following advantages:

- Participants can attend training at their own computers without leaving the office.
- Sessions are interactive as participants can ask questions during the session.
- If requested or needed, a session can be quickly organized to cover a specific topic for a small group or office.

For some larger training topics (such as ForwardHealth Portal Fundamentals), the training may be divided into individual modules, with each module focused on a particular subject. This allows participants to customize their training experience.

Registration, including an email address, is required to attend Virtual Room sessions, so important session information can be sent to participants prior to the start of the session. Online registration is available on the Trainings page of the Portal.

Recorded Webcasts

Recorded Webcasts are available on a variety of topics, including some of the same topics as on-site and online sessions. Like Virtual Room sessions, some recorded Webcasts on larger training topics may be divided into individual Webcast modules, allowing participants to customize their training experience. Recorded Webcasts allow providers to view the training at their convenience on their own computers.

Registration is not required to view a recorded Webcast. Related training materials are available to download and print from the specific webcast training session page on the Portal.

Notification of Training Opportunities

In addition to information on the Trainings page of the Portal, upcoming training session information is distributed directly through messages to providers who have secure Portal accounts and to providers who have registered for the ForwardHealth email subscription service.

To sign up for a secure Portal account, click the Request Portal Access link in the Quick Links box on the Provider page of the Portal. To sign up for email subscription, click Register for Email Subscription in the Quick Links box on the Provider page of the Portal.

Updates

Topic #478

Accessing ForwardHealth Communications

ForwardHealth Updates announce changes in policy and coverage, PA (prior authorization) requirements, and claim submission requirements. They communicate new initiatives from the Wisconsin Department of Health Services or new requirements from the federal Centers for Medicare and Medicaid Services and the Wisconsin state legislature.

Updates reflect current policy at the time of publication; this information may change over time and be revised by a subsequent Update. Update information is added to the Online Handbook after the Update is posted, unless otherwise noted.

Providers should refer to the ForwardHealth Online Handbook for current information. The Online Handbook is the source for current ForwardHealth policy and contains provider-specific information for various services and benefits.

Topic #4458

Electronic Notifications from ForwardHealth

ForwardHealth sends electronic messaging using both email subscription and secure Portal messaging to notify providers of newly released ForwardHealth Updates. ForwardHealth also uses electronic messaging to communicate training opportunities and other timely information.

Secure Portal Messages

Providers who have established a secure ForwardHealth Portal account automatically receive messages from ForwardHealth in their secure Portal Messages inbox.

Email Subscription Messages

Providers and other interested parties may register to receive email subscription notifications. When registering for email subscription, providers and other interested parties are able to select, by program (for example, Wisconsin Medicaid, BadgerCare Plus, HDAP (Wisconsin HIV Drug Assistance Program), or WCDP (Wisconsin Chronic Disease Program)), provider type (for example, physician, hospital, DME (durable medical equipment) vendor), and/or specific area of interest, (Trading Partner and ICD-10 (International Classification of Diseases, 10th Revision) Project Information) to designate what information they would like to receive. Any number of staff or other interested parties from an organization may sign up for an email subscription and may select multiple subscription options.

Registering for Email Subscription

Users may sign up for an email subscription by following these steps:

1. Click the Register for Email Subscription link on the ForwardHealth Portal home page.
2. The Subscriptions page will be displayed. In the Email field in the New Subscriber section, enter the email address to which messages should be sent.
3. Enter the email address again in the Confirm Email field.

4. Click Register. A message will be displayed at the top of the Subscriptions page indicating the registration was successful. If there are any problems with the registration, an error message will be displayed instead.
5. Once registration is complete, click the program for which you want to receive messages in the Available Subscriptions section of the Subscriptions page. The selected program will expand and a list of service areas will be displayed.
6. Select the service area(s) for which you want to receive messages. Click Select All if you want to receive messages for all service areas.
7. When service area selection is complete, click Save at the bottom of the page.

The selected subscriptions will load and a confirmation message will appear at the top of the page.

Topic #4460

Full Text Publications Available

Providers without internet access may call Provider Services to request that a paper copy of a ForwardHealth Update be mailed to them. To expedite the call, correspondents will ask providers for the Update number. Providers should allow seven to 10 business days for delivery.

WiCall

Topic #257

Enrollment Inquiries

WiCall is an AVR (Automated Voice Response) system that allows providers with phones direct access to enrollment information.

Information from WiCall will be returned in the following order if applicable to the member's current enrollment:

- Transaction number: A number will be given as a transaction confirmation that providers should keep for their records.
- Benefit enrollment: All benefit plans the member is enrolled in on the DOS (date of service) or within the DOS range selected for the financial payer.
- County code: The member's county code will be provided if available. The county code is a two-digit code between 01 and 72 that represents the county in which member resides. If the enrollment response reflects that the member resides in a designated HPSA (Health Personnel Shortage Area) on the DOS or within the DOS range selected, HPSA information will be given.
- MCO (managed care organization): All information about state-contracted MCO enrollment, including MCO names and telephone numbers, that exists on the DOS or within the DOS range selected will be listed. This information is applicable to Medicaid and BadgerCare Plus members only.
- Hospice: If the member is enrolled in the hospice benefit on the DOS or within the DOS range that the provider selected, the hospice information will be given. This information is applicable to Medicaid and BadgerCare Plus members only.
- Lock-in: Information about the Pharmacy Services Lock-In Program that exists on the DOS or within the DOS range selected will be provided. This information is applicable to Medicaid, BadgerCare Plus, and SeniorCare members only.
- Medicare: All information about Medicare coverage, including type of coverage and Medicare member ID, if available, that exists on the DOS or within the DOS range selected will be listed.
- Commercial health insurance coverage: All information about commercial coverage, including carrier names and telephone numbers, if available, that exists on the DOS or within the DOS range selected will be listed.
- Transaction completed: After the member's enrollment information has been given using the financial payer that was selected, providers will be given the following options to:
  - Hear the information again.
  - Request enrollment information for the same member using a different financial payer.
  - Hear another member's enrollment information using the same financial payer.
  - Hear another member's enrollment information using a different financial payer.
  - Return to the main menu.

WiCall is available 24 hours a day, seven days a week. If for some reason the system is unavailable, providers may call Provider Services.

Transaction Number

The AVR system issues a transaction number every time a provider verifies enrollment, even when an individual is **not** enrolled in BadgerCare Plus or Wisconsin Medicaid. The provider should retain this transaction number. It is proof that an inquiry was made about the member's enrollment. If a provider thinks a claim was denied in error, the provider can reference the transaction number to ForwardHealth to confirm the enrollment response that was actually given.

Topic #6257

Entering Letters into WiCall

For some WiCall inquries, health care providers are required to enter their taxonomy code with their NPI (National Provider Identifier). Because taxonomy codes are a combination of numbers and letters, telephone key pad combinations, shown in the table below, allow providers to successfully enter taxonomy code letters for WiCall functions (for example, press *21 to enter an A, press *72 to enter an R).

Letter	Key Combination	Letter	Key Combination
A	*21	N	*62
B	*22	O	*63
C	*23	P	*71
D	*31	Q	*11
E	*32	R	*72
F	*33	S	*73
G	*41	T	*81
H	*42	U	*82
I	*43	V	*83
J	*51	W	*91
K	*52	X	*92
L	*53	Y	*93
M	*61	Z	*12

Additionally, providers may select option 9 and press # for an automated voice explanation of how to enter letters in WiCall.

Topic #466

Information Available via WiCall

WiCall, ForwardHealth's AVR (Automated Voice Response) system, gathers inquiry information from callers through voice prompts and accesses ForwardHealth interChange to retrieve and "speak" back the following ForwardHealth information:

- Claim status
- Enrollment verification
- PA (prior authorization) status
- Provider CheckWrite information

Note: ForwardHealth releases CheckWrite information to WiCall no sooner than on the first state business day following the financial cycle.

Providers are prompted to enter NPI (National Provider Identifier) or provider ID and in some cases, NPI-related data, to retrieve query information.

In all inquiry scenarios, WiCall offers the following options after information is retrieved and reported back to the caller:

- Repeat the information.
- Make another inquiry of the same type.
- Return to the main menu.
- Repeat the options.

Claim Status

Providers may check the status of a specific claim by selecting the applicable financial payer program, (for example, Wisconsin Medicaid, WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)) and entering their provider ID, member identification number, DOS (date of service), and the amount billed.

Note: Claim information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Enrollment Verification

Providers may request enrollment status for any date of eligibility the member has on file by entering their provider ID and the member ID. If the member ID is unknown, providers may enter the member's date of birth and SSN (Social Security number). Additionally, the provider is prompted to enter the From DOS and the To DOS for the inquiry. The From DOS is the earliest date the provider requires enrollment information and the To DOS must be within 365 days of the "From" DOS.

Each time a provider verifies member enrollment, the enrollment verification is saved and assigned a transaction number as transaction confirmation. Providers should note the transaction number for their records.

PA Status

Except in certain instances, providers may obtain the status of PA requests for Medicaid and WCDP via WiCall by entering their provider ID and the applicable PA number. If the provider does not know the PA number, there is an option to bypass entering the PA number and the caller will be prompted to enter other PA information such as member ID and type of service (for example, NDC (National Drug Code), procedure code, revenue code, or ICD (International Classification of Diseases) procedure code). When a match is found, WiCall reports back the PA status information, including the PA number for future reference, and the applicable program.

Information on past PAs is retained indefinitely. Paper PAs require a maximum of 20 working days from receipt to be processed and incorporated into WiCall's PA status information.

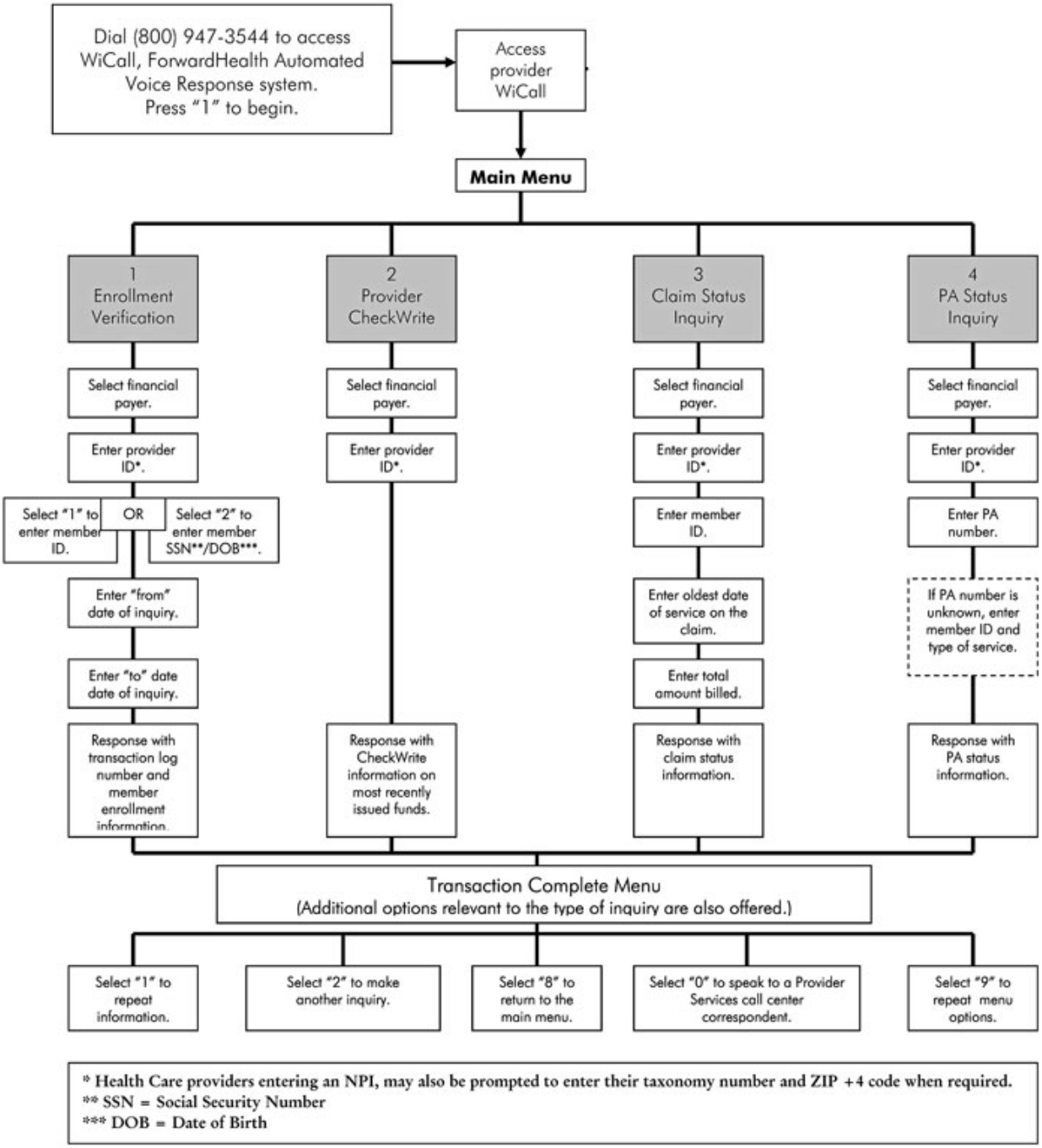
Note: PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Topic #765

Quick Reference Guide

The WiCall AVR (Automated Voice Response) Quick Reference Guide displays the information available for WiCall inquiries.

Automated Voice Response Quick Reference Guide



* Health Care providers entering an NPI, may also be prompted to enter their taxonomy number and ZIP +4 code when required.
** SSN = Social Security Number
*** DOB = Date of Birth