Claims

1

Archive Date:06/03/2013

Claims:Adjustment Requests

Topic #512

Electronic

837 Transaction

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

Provider Electronic Solutions Software

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

Portal Claim Adjustments

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

Topic #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.

Overpayments

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 #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 #11537

National Correct Coding Initiative

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

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

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

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

Medically Unlikely Detail Edits

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

An example of an MUE would be if procedure code 11100 (i.e., biopsy of skin lesion) was billed with a quantity of two or more. This procedure is medically unlikely to occur more than once; therefore, if it is billed with units greater than one, the detail will be denied.

Procedure-to-Procedure Detail Edits

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

An example of a procedure-to-procedure edit would be if procedure codes 11451 (i.e., removal of a sweat gland lesion) and 93000 (i.e., electrocardiogram) were billed on the same claim for the same DOS. Procedure code 11451 describes a more complex service than procedure code 93000 and therefore, the secondary procedure would be denied.

Quarterly Code List Updates

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

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

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

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

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

- Complete the Adjustment/Reconsideration Request (F-13046 (07/12)) form. In Element 16, select the "Consultant review requested" checkbox and the "Other/comments" checkbox. In the "Other/comments" text box, indicate "Reconsideration of an NCCI denial."
- Attach notes/supporting documentation.
- Submit a claim, Adjustment/Reconsideration Request, and additional notes/supporting documentation to ForwardHealth for processing.

Topic #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.

Submission

Topic #6957

Copy Claims on the ForwardHealth Portal

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

Topic #5017

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

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

Topic #4997

Direct Data Entry of Professional and Institutional Claims on the Portal

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

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

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

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

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

- Procedure codes.
- Modifiers.
- Diagnosis codes.

- Place of service codes.

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

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

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

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

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

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

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

Topic #344

Electronic Claim Submission

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

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

Topic #1908

Electronic Claim Submission for Rural Health Clinic Services

Electronic claims for RHC (rural health clinic) services must be submitted using either the 837P (837 Health Care Claim:

Professional) or 837I (837 Health Care Claim: Institutional) transaction. Providers should refer to their service-specific area to determine which transaction to use. Electronic claims for RHCs submitted using any transaction other than the 837P or 837I will be denied.

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

Provider Electronic Solutions Software

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

Topic #1909

Encounters and Claims Submission

Through the Wisconsin Medicaid RHC (rural health clinic) annual cost report, RHCs may claim cost-based reimbursement for member visits that meet the encounter criteria. Encounters are based on paid Medicaid or BadgerCare Plus HMO and fee-for-service claims. Therefore, it is important for RHCs to submit claims to ForwardHealth properly to ensure identification of all eligible encounters. Refer to service-specific areas for complete claims submission information and instructions.

Reimbursement Available and Billing Requirements

When an enrolled member's record shows the member has commercial insurance, use the following guidelines for fee-for-service billing.

Submit a fee-for-service claim to ForwardHealth when commercial insurance reimburses either one of the following:

- Less than the current year's final settlement Medicaid encounter rate and less than the charge.
- Zero or denies coverage.

Report the Medicaid encounter and any commercial insurance payments received in the Medicaid cost report.

Do not submit a fee-for-service claim to ForwardHealth when commercial insurance reimburses either one of the following:

- An amount greater than the current year's final settlement Medicaid encounter rate.
- The full amount of the charge.

Do not include the encounter or payments received in the Medicaid cost report.

The following are some examples illustrating this in practice. For simplicity, Medicaid's RHC encounter rate will be $60 and its maximum fee-for-service reimbursement will be $30 in each of the following scenarios.

Scenario 1

When insurance denies or reimburses zero, but the member record indicates commercial insurance coverage, then:

- Bill the fee-for-service claims system.
- Include the encounter and payments received in the Medicaid cost report.
- This is considered a Medicaid-only encounter.

Example:

- RHC charges = $50.
- Paid by insurance = $0.
- Bill fee-for-service? Yes.
- Fee-for-service payment = $30 (indicated in the Medicaid cost report).
- Include the encounter and insurance payment in the Medicaid cost report? = Yes.

Note: $60 (encounter rate) - $30 (fee-for-service payment) = $30 (amount payable to provider at final settlement.

Scenario 2

When insurance reimburses your RHC charges in full, then:

- Do not bill the Medicaid fee-for-service claims system.
- Do not include the encounter in the Medicaid cost report.

Example:

- RHC charges = $42.
- Paid by insurance = $42.
- Bill fee-for-service? No.
- Include the encounter and insurance payment in the Medicaid cost report? = No.

Scenario 3

When insurance reimburses less than your RHC charges and less than the RHC encounter rate, but more than Medicaid or BadgerCare Plus' fee-for-service maximum allowable fee, then:

- Bill the fee-for-service claims system.
- Include the encounter and the payments received in the Medicaid cost report.

Example:

- RHC charges = $65.
- Paid by insurance = $45.
- Bill fee-for-service? Yes.
- Fee-for-service payment (indicated in the Medicaid cost report) = $0.
- Include the encounter and insurance payment in the Medicaid cost report? = Yes.

Note: $60 (encounter rate) - $45 (insurance payment) = $15 (amount payable to provider at final settlement).

Scenario 4

When insurance reimburses less than your RHC charges, less than Medicaid or BadgerCare Plus's fee-for-service maximum allowable fee, and less than the RHC encounter rate, then:

- Bill the fee-for-service claims system.
- Include the encounter and the payments in the Medicaid cost report.

Example:

- RHC charges = $50.
- Paid by insurance = $25.
- Bill fee-for-service? Yes.
- Fee-for-service payment (indicated in the Medicaid cost report) = $5.
- Include the encounter and insurance payment in the Medicaid cost report? = Yes.

Note: $50 (charge) - $25 (insurance payment) - $5 (fee-for-service payment) = $20 (amount payable to provider at final settlement).

Scenario 5

When insurance reimburses more than your RHC encounter rate and less than your RHC charges, then:

- Do not bill the fee-for-service claims system.
- Do not include the encounter and the payments in the Medicaid cost report.

Example:

- RHC charges = $80.
- Paid by insurance = $70.
- Bill Medicaid FFS? No.
- Include the encounter and insurance payment in the Medicaid cost report? No.

Commercial Insurance Requirement and Verification

Federal and state regulations require providers to bill a member's commercial insurance plan and Medicare before billing Medicaid.

To verify whether the member has commercial insurance, providers may access the EVS (Wisconsin's Enrollment Verification System), which includes the following enrollment verification methods:

- A magnetic stripe card reader that may be purchased through a commercial enrollment verification vendor.
- Personal computer software that may be purchased through a commercial enrollment verification vendor.
- WiCall, Wisconsin's AVR (Automated Voice Response) system.
- Provider Services.

Providers may not hold members responsible for any commercial cost-sharing amounts, such as copayments, deductibles, or coinsurance.

Topic #10837

Note Field for Most Claims Submitted Electronically

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

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

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

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

- Professional.
- Institutional.
- Dental.

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

Claims Submitted Via 837 Health Care Claim Transactions

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

Topic #1919

Outpatient Mental Health/Substance Abuse Services

Psychiatrists and Ph.D. psychologists who are Medicaid-enrolled and are either employed by or under contract with an RHC (rural health clinic) may submit claims for outpatient mental health or substance abuse services under the RHC billing NPI (National Provider Identifier). These services are eligible for cost-based reimbursement.

Master's-level therapists and substance abuse counselors must work in an enrolled mental health or substance abuse clinic and may submit claims for services only through a licensed, Medicaid-enrolled outpatient mental health or substance abuse clinic. An RHC must become enrolled as an outpatient mental health or substance abuse clinic to use the services of a Master's level therapist and report them as RHC service costs and encounters on the Medicaid cost report.

Topic #561

Paper Claim Form Preparation and Data Alignment Requirements

Optical Character Recognition

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

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

Speed and Accuracy of Claims Processing

OCR software processes claim forms by reading text within fields on claim forms. After a paper claim form is received by

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

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

Handwritten Claims

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

Use Original Claim Forms

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

Use Laser or Ink Jet Printers

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

Alignment

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

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

The following sample claim forms demonstrate correct and incorrect alignment:

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

Clarity

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

stop, prompting manual review.

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

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

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

Staples, Correction Liquid, and Correction Tape

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

Additional Diagnosis Codes

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

Anchor Fields

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

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

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

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

Since ForwardHealth uses these fields to identify the form as a 1500 Health Insurance Claim Form or a UB-04 Claim Form, it is

required that these fields are completed for processing.

Sample of a Correctly Aligned 1500 Health Insurance Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE (Medicare #) ☒ MEDICAID (Medicaid #) ☐ TRICARE CHAMPUS (Sponsor's SSN) ☐ CHAMPVA (Member ID#) ☐ GROUP HEALTH PLAN (SSN or ID) ☐ FECA BLK LUNG (SSN) ☐ OTHER (ID) ☐			1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MEMBER, IM A	3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY; SEX M ☐ F ☒		4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME
5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐		7. INSURED'S ADDRESS (No., Street)
CITY: ANYTOWN; STATE: WI	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐		CITY; STATE
ZIP CODE: 55555; TELEPHONE (Include Area Code): (444) 444-4444	Employed ☐ Full-Time Student ☐ Part-Time Student ☐		ZIP CODE; TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P	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. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.
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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 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. RESERVED FOR LOCAL USE			20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. XXX . X 2. _____ 3. _____ 4. _____			22. MEDICAID 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 $ XX XX; 30. BALANCE DUE $ XX XX
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Provider SIGNED MMDDCCYY DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234 a. 0222222220 b. ZZ123456789X

NUCC Instruction Manual available at: www.nucc.org

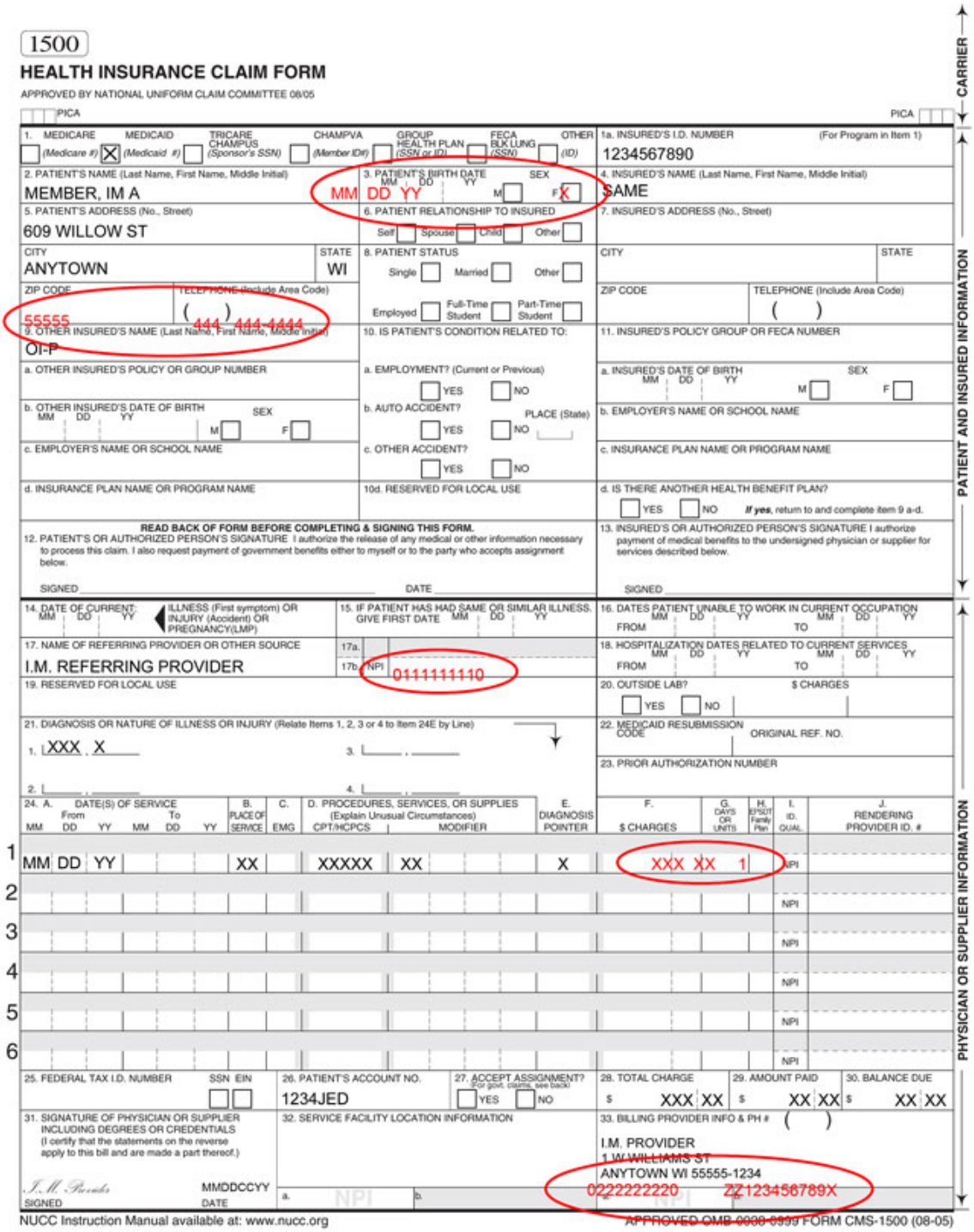
APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample of an Incorrectly Aligned 1500 Health Insurance Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | 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. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

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

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete item 9 a-d.

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

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

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

17a.

17b. NPI 0111111110

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. XXX . X 3. . 2. . 4. .

22. MEDICAID 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 $ XX XX

30. BALANCE DUE $ XX XX

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

I.M. Provider SIGNED MMDDCCYY 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

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

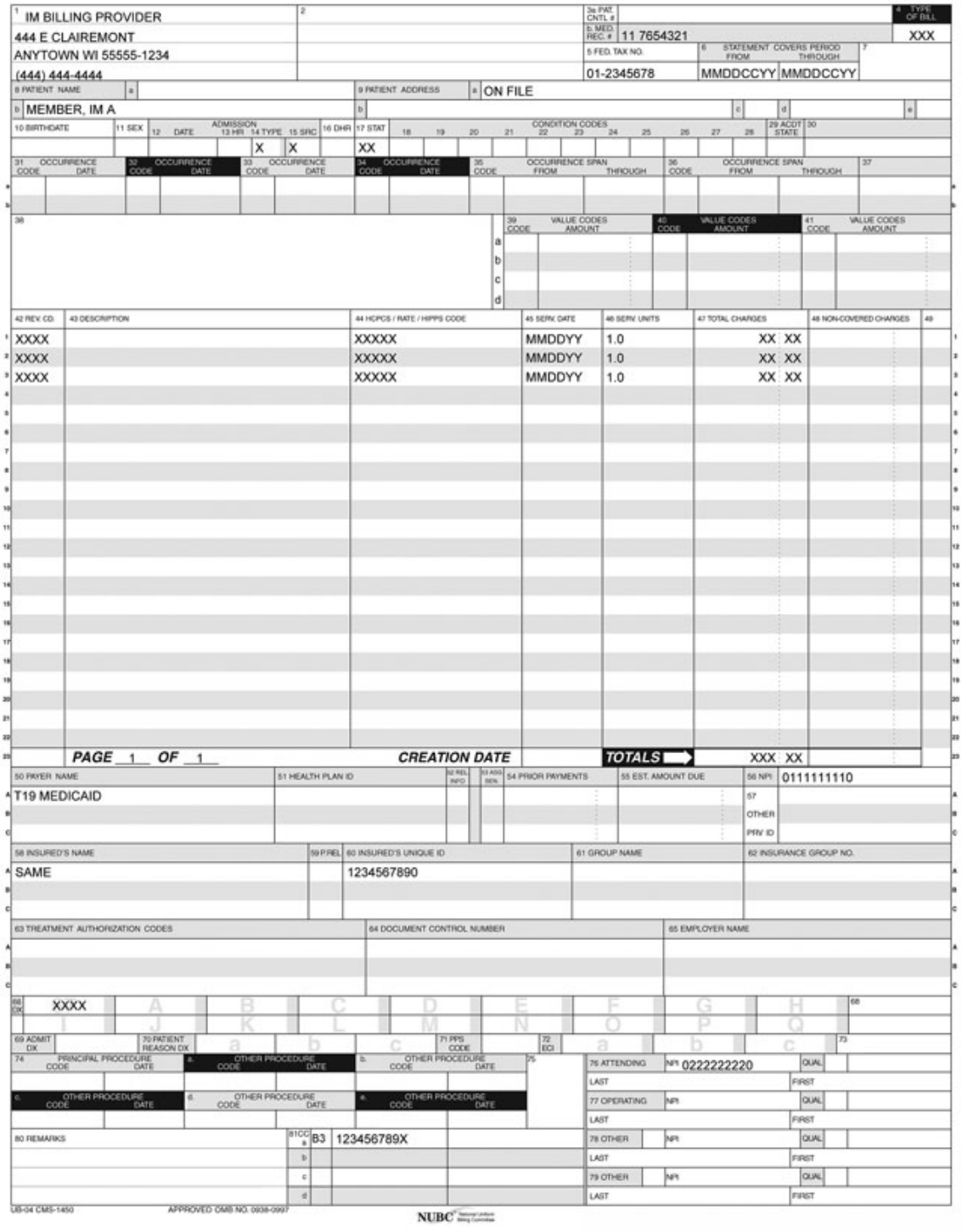
APPROVED OMB 0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample of a Correctly Aligned UB-04 Claim Form



1 IM BILLING PROVIDER 444 E CLAIREMONT ANYTOWN WI 55555-1234 (444) 444-4444	3a PAT. CNTL # b. MED. REC. # 11 7654321 4 TYPE OF BILL XXX 5 FED. TAX NO. 01-2345678 6 STATEMENT COVERS PERIOD FROM MMDDCCYY THROUGH MMDDCCYY
8 PATIENT NAME b MEMBER, IM A	9 PATIENT ADDRESS a ON FILE
10 BIRTHDATE / 11 SEX / 12 ADMISSION DATE / 13 HR / 14 TYPE X / 15 SRC X / 16 DHR / 17 STAT XX / 18–28 CONDITION CODES / 29 ACDT STATE / 30	
31–37 OCCURRENCE CODE / DATE; OCCURRENCE SPAN CODE / FROM / THROUGH	
38	39–41 VALUE CODES / AMOUNT (a–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 / 57 OTHER PRV ID
T19 MEDICAID						

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

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX: XXXX (A–Q) 68

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

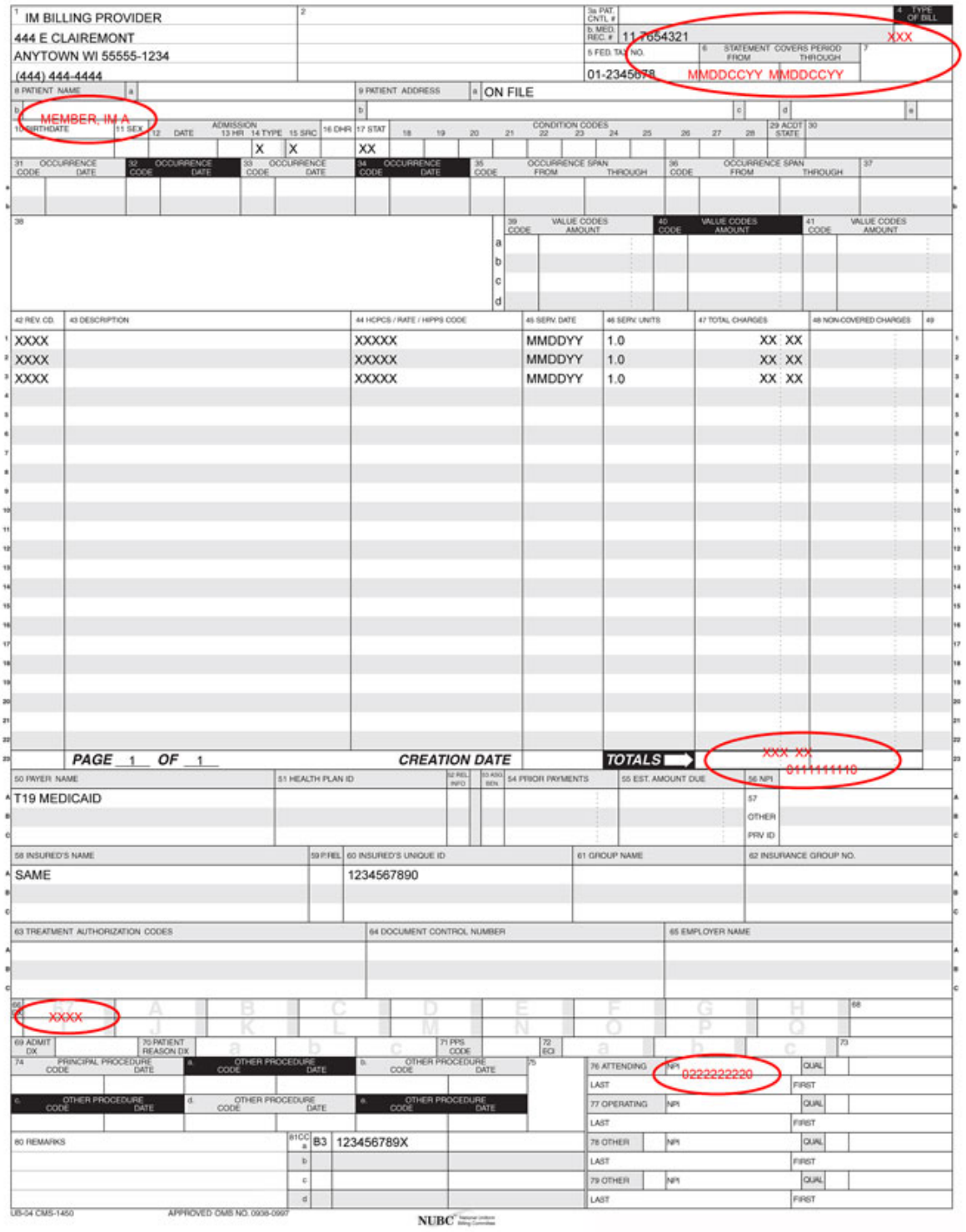
74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	

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

80 REMARKS	81CC a		
		B3	123456789X

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

Sample of an Incorrectly Aligned UB-04 Claim Form



Topic #1907

Paper Claim Submission

Paper claims for RHC (rural health clinic) services must be submitted using the 1500 Health Insurance Claim Form (dated 08/05) or the UB-04 Caim Form. Providers should refer to the appropriate service area to determine which claim form to use.

Claims submitted on any paper claim form other than these are denied.

Obtaining the Claim Forms

ForwardHealth does not provide these claim forms. The forms may be obtained from any federal forms supplier.

Topic #10637

Reimbursement Reduction for Most Paper Claims

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

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

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

The reimbursement reduction applies to the following paper claims:

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

Exceptions to Paper Claim Reimbursement Reduction

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

- In-state emergency providers.
- Out-of-state providers.
- Medicare crossover claims.
- Any claims that ForwardHealth requires additional supporting information to be submitted on paper. For example:
  - Hysterectomy claims must be submitted along with a paper Acknowledgment of Receipt of Hysterectomy Information (F-1160A (10/08)) form.
  - Sterilization claims must be submitted along with a paper Consent for Sterilization (F-1164 (10/08)) form.
  - Claims submitted to Timely Filing appeals must be submitted on paper with a Timely Filing Appeals Request (F-13047 (07/12)) form.
  - In certain circumstances, drug claims must be submitted on paper with a Pharmacy Special Handling Request (F-13074 (07/12)) form.

Topic #4817

Submitting Paper Attachments with Electronic Claims

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

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

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

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

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

This does not apply to compound and noncompound claims.

Covered and Noncovered Services

2

Archive Date:06/03/2013

Covered and Noncovered Services:Codes

Topic #830

Diagnosis Codes

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

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

Topic #1906

All claims submitted for RHC (rural health clinic) services must include an appropriate diagnosis code from the ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) coding structure. Claims received without an appropriate ICD-9-CM coding structure are denied.

Topic #1905

Procedure Codes

Use the single five-character CPT (Current Procedural Terminology) procedure code, HCPCS (Healthcare Common Procedure Coding System) procedure code, approved local procedure code, or revenue code that best describes the service performed, as appropriate. Claims without an appropriate procedure code are denied. Providers should refer to service-specific areas for current procedure code information.

Do not use multiple procedure codes to describe a single service.

Topic #643

Unlisted Procedure Codes

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

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

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

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

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

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

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

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

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

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

Unlisted Codes That Do Not Require Prior Authorization

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

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

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

How to Submit Claims and Related Documentation

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

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

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

Covered Services and Requirements

Topic #1925

An Overview

An RHC (rural health clinic) is a primary care clinic serving a rural, underserved area and is eligible for cost-based reimbursement from Wisconsin Medicaid for specific services, known as RHC services. In addition, RHCs provide a range of medical and surgical services for which they may be reimbursed based on the appropriate provider-specific maximum allowable fee schedule.

Cost-based reimbursement is based on an RHC's "reasonable costs." Reasonable costs are determined using Medicare reasonable cost principles. Generally, RHCs report reasonable costs on an annual cost report, which is used to generate an average rate per visit, also known as an encounter rate. The encounter rate is applied to member visits that meet the encounter criteria to generate a settlement amount. The settlement amount is paid to the RHC in a lump sum.

Topic #4292

Benchmark Plan Coverage

Services provided to Medicaid, BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, and BadgerCare Plus Core Plan members are eligible for inclusion on cost reports.

Topic #1903

Covered Services That Are Not Rural Health Clinic Services

There are items and services covered and reimbursable by Wisconsin Medicaid that do not fall under the definition of RHC (rural health clinic) services and may not be claimed as RHC service costs or encounters on the cost report. Nevertheless, RHCs may be reimbursed by Medicaid fee-for-service for these services if they are appropriately enrolled and have the appropriate billing provider NPI (National Provider Identifier). Further information concerning coverage and payment procedures for non-RHC services may be obtained from the appropriate service-specific area.

Covered items or services that cannot be included in the cost report as RHC service costs or encounters include, but are not limited to, the following:

- Ambulance services.
- Charges for hearing aids or eyeglasses.
- Diagnostic tests, unless an interpretation of the test is provided by an RHC physician.
- DME (durable medical equipment) (whether rented or sold), including oxygen tents, hospital beds, and wheelchairs used in the member's place of residence.
- Drugs routinely self-administered.
- Home health therapy or aide services.
- Laboratory services, diagnostic and screening.
- Leg, arm, back, and neck braces and artificial legs, arms, and eyes, including replacements (if required because of a change in the member's physical condition).

- Services provided to inpatient or outpatient hospital members.

Reimbursement is not available for for noncovered outpatient mental health and substance abuse services.

Topic #44

Definition of Covered Services

A covered service is a service, item, or supply for which reimbursement is available when *all* program requirements are met. DHS 101.03(35) and 107, Wis. Admin. Code, contain more information about covered services.

Topic #1904

Home Health Services

Intermittent visiting nurse care and related medical services, other than drugs and biologicals, are covered as RHC (rural health clinic) services when:

- The clinic is located in an area where there is a shortage of home health agencies.
- Services are provided by an RN (registered nurse) or LPN (licensed practical nurse).
- The services are furnished under a written plan of treatment that is established and reviewed at least every 60 days by a supervising physician of the RHC or established by a physician, physician assistant, or nurse practitioner and reviewed and approved every 60 days by a supervising physician of the RHC.

RHCs interested in providing home health services should call Provider Services and ask to speak with the DHCAA (Division of Health Care Access and Accountability) RHC Analyst.

Covered Services

For complete information on covered services and PA (prior authorization), providers can refer to the Home Health service area.

Topic #1902

Nurse Practitioner and Nurse Midwife Services

Nurse practitioner and nurse midwife services are covered as RHC (rural health clinic) services when the services are:

- Provided by a nurse practitioner or nurse midwife employed by or under contract with an RHC.
- Performed under the general supervision of a physician.
- Provided in accordance with clinic policies for a patient's care and treatment.
- Performed within the legal scope of practice as defined under the Wisconsin Board of Nursing licensure or certification.
- Included in the individual nurse practitioner's protocols or a collaborative relationship with a physician as defined by the Board of Nursing.

Nurse practitioner and nurse midwife services include diagnosis, treatment, therapy, and consultation performed directly by a nurse practitioner or nurse midwife.

Supervision

Medicaid-enrolled nurse practitioners who work under the general supervision of a physician are required to be supervised to the extent required pursuant to Board of Nursing N 6.02(7), Wis. Admin. Code, which 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.

Pursuant to Board of Nursing N 8.10(7), Wis. Admin. Code, APNPs (advanced practice nurse prescribers) work in a collaborative relationship with a physician. The collaborative relationship means an APNP 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."

Clinics that are not physician directed must arrange with a physician to provide supervision and guidance to nurse practitioners and nurse midwives, according to protocols and established clinic policies and procedures. The arrangement must be consistent with Wisconsin state law. The physician must be a doctor of medicine or osteopathy.

In the case of a physician-directed clinic, one or more clinic staff physicians must perform general supervision of nurse practitioners and nurse midwives.

Covered Services

Medically necessary nurse practitioner and nurse midwife services are covered when they are also considered covered physician services.

Medicaid-enrolled nurse midwives are limited to providing the following categories of covered services:

- Family planning services.
- Laboratory services.
- Obstetric services.
- Office and outpatient visits.
- TB (Tuberculosis)-related services.

The practice of nurse midwifery means the management of women's health care, pregnancy, childbirth, postpartum care for newborns, family planning, and gynecological services consistent with the standards of practice of the American College of Nurse Midwives and the education, training, and experience of the nurse midwife (Board of Nursing s. 441.15, Wis. Stats.).

Only antepartum and postpartum visits and outpatient treatment of complications are eligible for cost-based reimbursement.

Topic #1901

Obstetric Services

Providers have a choice of how and when to file claims for OB (obstetric) care. Providers may choose to submit claims using either the separate OB component procedure codes as they are performed or the appropriate global OB procedure code with the date of delivery as the DOS (date of service).

Note: Only antepartum and postpartum care services are considered RHC (rural health clinic) services (i.e., they can be included on the annual and quarterly Medicaid RHC cost reports). Deliveries, while they may be covered by Medicaid or BadgerCare Plus, are not RHC services, and, therefore, they cannot be included on the cost report.

Wisconsin Medicaid will not reimburse individual antepartum care, delivery, or postpartum care codes if a provider also submits a claim for global OB 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 (see "Delivery" for details).

Separate Obstetric Care Components

Providers should use the following guidelines when submitting claims for separate OB components.

Note: A telephone call between a member and a provider does not qualify as an office visit.

Antepartum Care

Antepartum care includes dipstick urinalysis, routine exams, and recording of weight, blood pressure, and fetal heart tones.

Providers should provide *all* antepartum care visits before submitting a claim to ForwardHealth.

Indicate CPT (Current Procedural Terminology) procedure codes 99204 with modifier "TH" (Obstetrical treatment/services, prenatal or postpartum) and 99213 with modifier "TH" when submitting claims for one to three total antepartum care visits with the same provider or provider group. For example, if a total of two or three antepartum care visits is performed during a woman's pregnancy, the provider should indicate procedure code 99204 with modifier "TH" and a quantity of "1.0" for the first DOS. For the second and third visits, the provider should indicate procedure code 99213 with modifier "TH" and a quantity of "1.0" or "2.0," as indicated in the table. The date of the last antepartum care visit is the DOS.

Similarly, for CPT codes 59425 (antepartum care only; 4-6 visits) and 59426 (antepartum care only; 7 or more visits), the provider should indicate the date of the last antepartum care visit as the DOS. The quantity indicated for these two codes may not exceed "1.0."

Antepartum Care Claims Submission Guide

Total Visit(s)	Procedure Code and Description*		Modifier and Description	Quantity
1	99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity (45 minutes)		TH (Obstetrical treatment/ services, prenatal or postpartum)	1.0
2	99204		TH	1.0
	99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity (15 minutes)		TH	1.0
3	99204		TH	1.0
	99213		TH	2.0
4-6	59425	Antepartum care only; 4-6 visits		1.0
7+	59426	7 or more visits		1.0

*Refer to the current CPT code book for a complete description of procedure codes 99204 and 99213.

Occasionally, a provider may be unsure of whether a member has had previous antepartum care with another provider. If the member is unable to provide this information, the provider should assume the first time he or she sees the member is the first antepartum visit.

Reimbursement for antepartum care (procedure codes 99204 with modifier "TH," 99213 with modifier "TH," 59425, and 59426) is limited to once per pregnancy, per member, per billing provider.

Postpartum Care

Postpartum care includes all routine management and care of the postpartum patient including exploration of the uterus, episiotomy and repair, repair of obstetrical lacerations and placement of hemostatic packs or agents. These are part of both the post-delivery and post-hospital office visits, both of which must occur in order to receive reimbursement for postpartum care or global obstetric care.

In accordance with the standards of the American College of Obstetricians and Gynecologists, Medicaid reimbursement for postpartum care includes *both* the routine post-delivery hospital care *and* an outpatient/office visit. Post-delivery hospital care alone is included in the reimbursement for delivery. When submitting a claim for postpartum care, the DOS is the date of the post-hospital discharge office visit. In order to receive reimbursement, the member *must* be seen in the office.

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

Reporting Antepartum Care and Postpartum Care Encounters on the Cost Report

To report encounters when claims for antepartum care and postpartum care only procedure codes have been submitted, include:

- The actual number of encounters.
- 100 percent of FFS (fee-for-service) payments received.

Global Obstetric Care

Providers may submit claims using global OB codes. However, the delivery component, although covered, is not an allowable RHC service.

Providers choosing to submit claims for global OB 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 OB care, providers should use the single most appropriate CPT OB procedure code and a single charge for the service. Use the date of delivery as the DOS.

All services must be performed to receive reimbursement for global obstetric care. Providers are required to provide all six (or more) antepartum visits, delivery, and the postpartum office visit in order to receive reimbursement for global OB 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 OB 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 Medicaid billing number and identify the primary OB provider as the rendering provider in this situation.

Reporting Global Obstetric Care Encounters on the Cost Report

To report encounters in the cost report when claims for OB services have been submitted using global OB codes, providers should use the following guidelines.

Report the actual number of antepartum and postpartum visits as encounters. Report the difference between the global OB procedure code reimbursement and the maximum fee for delivery as the amount reimbursed by Wisconsin Medicaid for the antepartum and postpartum care encounters. Providers should use the following table to determine which delivery code to use with the global OB codes.

When reporting encounters associated with a global OB code, use the date of delivery as the DOS.

Global OB Care CPT Codes and Corresponding Delivery CPT Codes			
Global OB CPT Codes		**Corresponding Delivery CPT Codes**	
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	59409	Vaginal delivery only (with or without episiotomy and/or forceps)
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	59514	Cesarean delivery only
59610	Routine obstretric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy, and/or forceps)
59618	Routine obstetric care, including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

Topic #1900

Other Ambulatory Services

Other ambulatory services that are included in a written plan of treatment and meet state plan requirements for furnishing those services, such as outpatient mental health/substance abuse services, are covered as RHC (rural health clinic) services. Other ambulatory services furnished by an RHC are not subject to the physician supervision requirements under DHS 105.35, Wis. Admin. Code.

Topic #1899

Outpatient Mental Health/Substance Abuse Services

Wisconsin Medicaid covers outpatient mental health and outpatient substance abuse services as RHC (rural health clinic) services when all of the following are met:

- The services must be provided by a psychiatrist, Ph.D. psychologist, a certified outpatient mental health clinic, DHS 75.13 or DHS 75.15, Wis. Admin. Code, or a certified substance abuse clinic.
- Psychiatrists, Ph.D. psychologists, Master's-level therapists, and substance abuse counselors must be individually enrolled in Wisconsin Medicaid and be either an RHC employee or under contract with the RHC.

- The certified outpatient mental health clinic or substance abuse clinic must also be enrolled in Wisconsin Medicaid.
- Outpatient psychotherapy services are provided in accordance with DHS 75.13(2) and DHS 75.13(3), Wis. Admin. Code.
- Outpatient substance abuse services are provided in accordance with DHS 75.13 or DFS 75.15, Wis. Admin. Code.

Covered Services

Allowable RHC services include mental health and substance abuse evaluations, psychotherapy, and substance abuse counseling. Covered services are those described in DHS 107.13(2) and DHS 107.13(3), Wis. Admin. Code. Refer to the Outpatient Mental Health and Substance Abuse service areas for complete information on covered outpatient mental health and outpatient substance abuse services.

Limitations

Refer to the Outpatient Mental Health and Substance Abuse service areas for complete information on limitations to covered Medicaid outpatient mental health/substance abuse services.

Reimbursement is not available for noncovered outpatient mental health and substance abuse services.

Topic #1898

Physician Services

Physician and Physician Assistant Services

Wisconsin Medicaid reimburses for professional services performed by Medicaid-enrolled physicians and physician assistants employed or under contract with an RHC (rural health clinic). However, cost-based RHC reimbursement is allowed only for RHC physician and physician assistant services. Physicians who perform outpatient mental health, outpatient substance abuse services, psychotherapy, vision services, or who dispense drugs should refer to the following service areas:

- Physician.
- Outpatient Mental Health.
- Outpatient Substance Abuse.
- Pharmacy (for physicians who dispense drugs).
- Vision.

The service areas for the above have information regarding covered services, PA (prior authorization) guidelines, and billing instructions.

Topic #1897

Rural Health Clinic Services Defined

RHCs (rural health clinics) are primary care clinics that provide a range of services defined as RHC services.

Wisconsin Medicaid defines RHC services as the following services:

- Physician and physician assistant services.
- Services and supplies incidental to physician and physician assistant services.
- Nurse practitioner and nurse midwife services.

- Services and supplies incidental to the services of nurse practitioners and nurse midwives.
- Intermittent visiting nurse care and related medical supplies, other than drugs and biologicals, if:
  - The clinic is located in an area where there is a shortage of home health agencies.
  - The services are furnished by a RN (registered nurse) or LPN (licensed practical nurse) employed by, or under contract with, the RHC.
  - The services are furnished to a homebound member, as defined in DHS 107.11(2), Wis. Admin. Code.
- Other ambulatory services included in the written plan of treatment that meet specific Medicaid state plan requirements for furnishing those services. These services include outpatient mental health/substance abuse services, such as those provided by a clinical psychologist or clinical social worker.

Wisconsin Medicaid reimburses only for those services that are medically necessary, appropriate, and the most cost effective, to the extent that alternative services are available.

Providers should refer to their appropriate service-specific areas for complete information about enrollment requirements, covered services, reimbursement methods, and claims submission.

Encounter Definition

An RHC-allowable encounter is defined as a face-to-face visit between a member and a Medicaid-enrolled provider to perform an RHC service. To be included as an encounter on the cost report, claims for the service provided must have been submitted and paid.

Topic #510

Telemedicine

Telemedicine services (also known as "Telehealth") are services provided from a remote location using a combination of interactive video, audio, and externally acquired images through a networking environment between a member (i.e., the originating site) and a Medicaid-enrolled provider at a remote location (i.e., distant site). The services must be of sufficient audio and visual fidelity and clarity as to be functionally equivalent to a face-to-face contact. Telemedicine services do not include telephone conversations or Internet-based communication between providers or between providers and members.

All applicable HIPAA (Health Information Portability and Accountability Act of 1996) confidentiality requirements apply to telemedicine encounters.

Reimbursable Telemedicine Services

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

- Physicians and physician clinics.
- RHCs (rural health clinics).
- FQHCs (federally qualified health centers).
- Physician assistants.
- Nurse practitioners.
- Nurse midwives.
- Psychiatrists in private practice.
- Ph.D. psychologists in private practice.

These providers may be reimbursed, as appropriate, for the following services provided through telemedicine:

- Office or other outpatient services (CPT (Current Procedural Terminology) procedure codes 99201-99205, 99211-

99215).
- Office or other outpatient consultations (CPT codes 99241-99245).
- Initial inpatient consultations (CPT codes 99251-99255).
- Outpatient mental health services (CPT codes 90801-90849, 90862, 90875, 90876, and 90887).
- Health and behavior assessment/intervention (CPT codes 96150-96152, 96154-96155).
- ESRD (end-stage renal disease)-related services (CPT codes 90951-90952, 90954-90958, 90960-90961).
- Outpatient substance abuse services (HCPCS (Healthcare Common Procedure Coding System) codes H0022, H0047, T1006).

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

Claims for services performed via telemedicine must include HCPCS modifier "GT" (via interactive audio and video telecommunication systems) with the appropriate procedure code and must be submitted on the 837P (837 Health Care Claim: Professional) transaction or 1500 Health Insurance Claim Form paper claim form. Reimbursement is the same for these services whether they are performed face-to-face or through telemedicine.

Only one eligible provider may be reimbursed per member per DOS (dates of service) for a service provided through telemedicine unless it is medically necessary for the participation of more than one provider. Justification for the participation of the additional provider must be included in the member's medical record.

Separate services provided by separate specialists for the same member at different times on the same DOS may be reimbursed separately.

Services Provided by Ancillary Providers

Claims for services provided through telemedicine by ancillary providers should continue to be submitted under the supervising physician's NPI (National Provider Identifier) using the lowest appropriate level office or outpatient visit procedure code or other appropriate CPT code for the service performed. These services must be provided under the direct on-site supervision of a physician and documented in the same manner as face-to-face services. Coverage is limited to procedure codes 99211 or 99212, as appropriate.

Federally Qualified Health Centers and Rural Health Clinics

Telemedicine may be reported as an encounter on the cost settlement report for both RHCs and FQHCs when both of the following are true:

- The RHC or FQHC is the distant site.
- The member is an established patient of the RHC or FQHC at the time of the telemedicine service.

Members Located in Nursing Homes

Claims for telemedicine services where the originating site is a nursing home should be submitted with the appropriate level office visit or consultation procedure code.

Out-of-State Providers

Out-of-state providers, except border-status providers, are required to obtain PA before delivering telemedicine-based services to Wisconsin Medicaid members.

Documentation Requirements

All telemedicine services must be thoroughly documented in the member's medical record in the same way as if it were performed as a face-to-face service.

Eligible Members

All members are eligible to receive services through telemedicine. Providers may not require the use of telemedicine as a condition of treating the member. Providers should develop their own methods of informed consent verifying that the member agrees to receive services via telemedicine.

Telemedicine and Enhanced Reimbursement

Providers may receive enhanced reimbursement for pediatric services (services for members 18 years of age and under) and HPSA (Health Professional Shortage Area)-eligible services performed via telemedicine in the same manner as face-to-face contacts. As with face-to-face visits, HPSA-enhanced reimbursement is allowed when either the member resides in or the provider is located in a HPSA-eligible ZIP code. Providers may submit claims for services performed through telemedicine that qualify for pediatric or HPSA-enhanced reimbursement with both modifier "GT" and the applicable pediatric or HPSA modifier.

Originating Site Facility Fee

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

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

Claim Submission

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

Code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital

22	Outpatient Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Facilities for Developmental Disabilities
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Nonresidential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

Outpatient Hospital Reimbursement

Wisconsin Medicaid will reimburse outpatient hospitals only the facility fee (Q3014) for the service. Wisconsin Medicaid will separately reimburse an outpatient hospital for other covered outpatient hospital services only if they are provided beyond those included in the telemedicine service on the same DOS. Professional services provided in the outpatient hospital are separately reimbursable.

Store and Forward Services

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

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

EHR Incentive Program

3

Archive Date:06/03/2013

EHR Incentive Program:Adopting, Implementing, or Upgrading Certified EHR Technology

Topic #12102

Adopting EHR Technology

In order to qualify for a Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payment under "adoption," Eligible Professionals and Eligible Hospitals must demonstrate acquisition, installation, or contractual proof of a future acquisition of certified EHR technology in the first payment year. All information is subject to audit at any time and must be maintained by the Eligible Professional or Eligible Hospital for a period of six years. If selected for audit, the applicant must be able to supply one of the following items:

- Receipt(s) for certified EHR technology. The receipt must match the products associated with the CMS (Centers for Medicare and Medicaid Services) EHR certification ID the applicant received from the ONC (Office of the National Coordinator for Health Information Technology) for Health IT Certifed EHR Product List and reported through the application process.
- A contract for certified EHR technology. The products listed in the contract must match the products associated with the CMS EHR certification ID the applicant received from ONC's Certified Health IT Product List and reported through the application process.

Additional documentation may be considered but must, at a minimum, identify the certified EHR technology adopted and indicate the certified EHR technology acquired or purchased.

Topic #12103

Implementing EHR Technology

In order to qualify for a Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payment under "implementation," Eligible Professionals and Eligible Hospitals must meet the criteria for adopting certified EHR technology and demonstrate actual implementation, installation, or utilization of certified EHR technology. Examples of how to demonstrate implementation of certified EHR technology includes completing a workflow analysis and redesign, training staff on the use of modules, and patient demographics and administrative data. All information is subject to audit at any time and must be maintained by the Eligible Professional or Eligible Hospital for a period of six years. If selected for audit, the applicant must be able to supply at least one document from each of the following lists:

List One:

- Receipt(s) for certified EHR technology. The receipt must match the products associated with the CMS (Centers for Medicare and Medicaid Services) EHR certification ID that the applicant received from the ONC (Office of the National Coordinator for Health Information Technology) Certified Health IT Product List and reported through the application process.
- A contract for certified EHR technology. The products listed in the contract must match the products associated with the CMS EHR certification ID the applicant received from ONC's Certified Health IT Product List and reported through the application process.

List Two:

- Maintenance agreement.
- Installation contract or receipts.
- System logs indentifying use of the certified technology and/or user license agreements.
- Evidence of cost, contract, or third party certification of certified EHR technology training.

Additional documentation may be considered but must, at a minimum, identify the certified EHR technology implemented and indicate the certified EHR technology acquired or purchased.

If attesting to "implementation," the Eligible Professional or Eligible Hospital will select from a list of implementation activities that are either "Planned" or "Completed." Some examples of these activities include workflow analysis, workflow redesigns, software installations, hardware installations, and peripheral installations.

Topic #12104

Upgrading EHR Technology

In order to qualify for a Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payment under "upgrade," Eligible Professionals and Eligible Hospitals must meet the criteria for adopting and implementing and demonstrate expansion of the certified EHR technology's functionality such as the addition of an e-prescribing functionality or CPOE (Computerized Physician Order Entry). All information is subject to audit at any time and must be maintained by the Eligible Professional or Eligible Hospitals for a period of six years. If selected for audit, the applicant must be able to supply one of the following items:

- Receipt(s) for certified EHR technology. The receipt must match the products associated with the CMS (Centers for Medicare and Medicaid Services) EHR certification ID the applicant received from the ONC (Office of the National Coordinator for Health Information Technology) Certified Health IT Product List and reported through the application process.
- Executed contract for certified EHR technology. The products in listed in the contract must match the products associated with the CMS EHR certification ID the applicant received from ONC's Certified Health IT Product List and reported through the application process.

Additional documentation may be considered but must, at a minimum, identify the certified EHR technology upgraded and indicate the certified EHR technology acquired or purchased.

Topic #12497

Uploading Documentation for Adopting, Implementation, and Upgrading Certified EHR Technology

It is recommended, but not required, that Eligible Professionals and Hospitals provide documentation supporting adoption, implementation, or upgrading of certified EHR (Electronic Health Record) technology. If attesting to adoption, implementation or upgrade, the Eligible Professional or Hospital may upload supporting documentation at the conclusion of the Wisconsin Medicaid EHR Incentive Program application. Eligible Professionals and Hospitals may upload any relevant documentation to support their attestations related to adopting, implementing or upgrading. This may include PDF (Portable Document Format) files (of no more than 2MBs) of purchase orders, vendor contracts to install the certified EHR technology, any other receipts, and any other auditable documentation.

All Eligible Professionals and Hospitals are reminded that they should maintain supporting documentation for the Wisconsin Medicaid EHR Incentive Program application in their files for six years.

An Overview

Topic #12037

Overview of the EHR Incentive Program

The EHR (Electronic Health Record) Incentive Program was established under the American Recovery and Reinvestment Act of 2009, also known as the "Stimulus Bill," to encourage certain eligible health care professionals and hospitals to adopt and become meaningful users of certified EHR technology.

Under the federal law, Medicare and Medicaid have separate EHR incentive programs. Eligible Professionals may register to participate in either the Medicare or Medicaid EHR Incentive Programs, but not both. Eligible Professionals may change their EHR Incentive Program election once, switching between Medicare and Medicaid, but the change in election must occur on or before December 31, 2014. All Eligible Professionals must be Wisconsin Medicaid-enrolled in order to participate in the Wisconsin Medicaid EHR Incentive Program. Eligible Professionals may participate in only one state's Medicaid EHR Incentive Program. Eligible Professionals should apply for EHR payments from the state with which they do most of their business.

Eligible Professionals must first register with the R&A (Medicare and Medicaid Electronic Health Record Incentive Program Registration and Attestation System). Eligible Professionals may then apply with the Wisconsin Medicaid EHR Incentive Program. All Wisconsin Medicaid EHR Incentive Program applications will be submitted through the secure Provider area of the ForwardHealth Portal.

Payments to Eligible Professionals will be made within 45 calendar days of the approval of a completed and submitted application. Eligible Professionals who meet all of the requirements may receive an incentive payment once per calendar year.

The Wisconsin Medicaid EHR Incentive Program will be available for Eligible Professionals from 2011 through 2021. The last date Eligible Professionals may register to begin receiving incentive payments for adopting, implementing, and upgrading EHR technology is December 31, 2016. Eligible Professionals may participate for a total of six years in the Wisconsin Medicaid EHR Incentive Program. Eligible Professionals are encouraged, but not required, to participate in all six allowed payment years.

The Wisconsin Medicaid EHR Incentive Program payment years are defined as calendar years and are composed in the following way:

- First payment year: Eligible Professionals are required to attest to adopting, implementing, or upgrading certified EHR technology.
- Second payment year: Eligible Professionals are required to demonstrate "meaningful use" of certified EHR technology during any 90-day, continuous period during the payment year.
- Third — sixth payment year: Eligible Professionals are required to demonstrate "meaningful use" of certified EHR technology for the entire payment year.

Eligible Professionals will have an additional 90-day grace period after the end of the Program Year to apply for an incentive payment for that Program Year. The Program Year for Eligible Professionals is based on the calendar year (i.e., January 1 - December 31).

Eligible Professionals should note that they are not required to participate in consecutive years of the Wisconsin Medicaid EHR Incentive Program. For example, an Eligible Professional may register and complete all requirements for the first year in 2011 and receive a payment but then wait until 2013 to demonstrate "meaningful use" during a 90-day, continuous period for the second payment year.

All information submitted on the Wisconsin Medicaid EHR Incentive Program application is subject to audit at any time.

Appeals

Topic #12137

Appeals Process

To file an appeal, the Eligible Professional or Hospital should log into the secure ForwardHealth Portal and select the new quick link called the "Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program Appeal" on the secure Portal homepage.

Eligible Professionals and Hospitals (or an authorized preparer) filing a Wisconsin Medicaid EHR Incentive Program appeal should have the following information on hand when initiating an appeal:

- The NPI (National Provider Identifier) of the Eligible Hospital or Eligible Professional submitting the appeal.
- The payment year for which the appeal is being submitted.
- The name, telephone number, email address, and the preferred method of contact of the person submitting the appeal (i.e., the Eligible Hospital, Eligible Professional, or authorized preparer).

Once the Wisconsin Medicaid EHR Incentive Program has validated that the NPI matches a current application, the Eligible Professional or Hospital will then be able to select the reason to appeal from a drop-down list of reasons or will be able to provide a statement in a free-form comment box.

If the Wisconsin Medicaid EHR Incentive Program cannot match the NPI supplied with a current application, the Eligible Professional or Hospital will receive the following message: "A Wisconsin Medicaid EHR Incentive Program application that is denied or approved for payment is not found for the Eligible Hospital/Professional submitted. Please verify the information entered. If you believe this message was received in error, contact Provider Services." The Eligible Professional or Hospital should then contact Provider Services.

After selecting the reason for the appeal or providing a statement in the free-form comment box, the Eligible Professional or Hospital will then be able to upload any relevant supporting documentation in support of their appeal. This documentation may include any PDF (Portable Document Format) files up to 5 MBs each. Eligible Hospitals and Eligible Professionals should note that they must upload all relevant supporting documentation at the time of submission, as they will not be able to return to the appeal application to upload any documentation after submitting the appeal. Eligible Professionals and Eligible Hospitals will also have the option of creating a PDF of their appeal for their files.

After submission of the appeal, Eligible Professionals or Hospitals will receive a tracking number that is assigned to each appeal. Eligible Professionals and Hospitals should have this tracking number on hand to reference if they need to contact Provider Services regarding their appeal.

Once an appeal has been filed, the Eligible Professional or Hospital will receive an e-mail confirming the receipt of the appeal request and a second e-mail confirming that the appeal request has been adjudicated. The Wisconsin Medicaid EHR Incentive Program will communicate the appeal determination through a decision letter, sent to the address provided during Wisconsin Medicaid EHR Incentive Program application process, within 90 days of receipt of all information needed to make a determination. The decision letter will state whether the appeal has been denied or approved.

Topic #12477

Valid Reasons to Appeal

Eligible Professionals and Hospitals may only appeal to the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program for the following reasons:

- To dispute the payment amount.
- To appeal a denied Wisconsin Medicaid EHR Incentive Program application.

Appealing a Payment Amount

Eligible Professionals and Hospitals who wish to appeal a payment amount must do so within 45 calendar days of the RA (Remittance Advice) date of the Wisconsin Medicaid EHR Incentive Program payment.

Appealing a Denied Wisconsin Medicaid Electronic Health Record Incentive Program Application

Eligible Professionals and Hospitals who do not qualify for a Wisconsin Medicaid EHR Incentive Program payment will receive a denial letter in the mail, sent to the address provided during the Wisconsin Medicaid EHR Incentive Program application process. The letter will explain why their Wisconsin Medicaid EHR Incentive Program application was denied. Eligible Professionals and Hospitals who wish to appeal a denied Wisconsin Medicaid EHR Incentive Program application must do so within 45 calendar days from the date on the denial letter.

Eligible Professionals and Hospitals should refer to the tables below for the following information:

- A complete list of valid application denial appeal reasons.
- Additional supporting documentation that the Eligible Professional or Hospital may be required to upload based on the type of appeal, including instances when a statement is needed from the Eligible Professional or Hospital in the appeals application free-form comment box.
- Appealing the payment amount.

Denied Application Appeals	
Reason for Appeal	**Documentation Needed**
The patient volume required by the CMS (Centers for Medicare and Medicaid Services) have not been met, see federal rule 42 CFR 495.304.	• For Eligible Hospitals, provide the out-of-state patient volume for the reported 90-day period on the Wisconsin Medicaid EHR Incentive Program application. • For Eligible Professionals, provide the patient volume for the reported 90-day period on the Wisconsin Medicaid EHR Incentive Program application.
The Eligible Hospital has indicated it is not an acute care hospital with an average length of stay of 25 days or less or a children's hospital.	Acute care and children's hospitals are required to have an average length of stay for patients of 25 days or less to qualify for the Wisconsin Medicaid EHR Incentive Program. If the question was answered incorrectly when completing the original Wisconsin Medicaid EHR Incentive Program application, provide a clarifying statement indicating the reason why the Eligible Hospital meets the requirements for the program.
The Eligible Hospital did not confirm to only participate in the Wisconsin Medicaid EHR Incentive Program.	Eligible Hospitals must agree to participate in only one state's Medicaid EHR Incentive Program. If the question was answered incorrectly when completing the original Wisconsin Medicaid EHR Incentive Program application, provide a clarifying statement that the Eligible Hospital confirms to only participate in the Wisconsin Medicaid EHR Incentive Program.

The Eligible Professional has indicated that they have current or pending sanctions with Medicare or Medicaid and therefore does not qualify for the Wisconsin Medicaid EHR Incentive Program.	Upload documentation proving the Eligible Professional has been reinstated by the Office of Inspector General. If the question was answered incorrectly when completing the original Wisconsin Medicaid EHR Incentive Program application, provide a clarifying statement that the Eligible Professional has no current or pending sanctions with Medicare or Medicaid.
The Eligible Professional has indicated that he or she is hospital based.	Eligible Professionals are not eligible for the Wisconsin Medicaid EHR Incentive Program if they provide 90 percent or more of their services to eligible members in an inpatient hospital or emergency department. If the question was answered incorrectly when completing the original Wisconsin Medicaid EHR Incentive Program application, provide a clarifying statement that the Eligible Professional is not hospital based.
The Eligible Professional has indicated they are not waiving their right to a Medicare EHR Incentive Program payment for this payment year. Eligible Professionals must select to register with either Medicare or Medicaid EHR Incentive Program, but not both.	Eligible Professionals may participate in either Medicare or Medicaid EHR Incentive Programs, but not both. If the question was answered incorrectly when completing the original Wisconsin Medicaid EHR Incentive Program application, provide a clarifying statement that the Eligible Professional is waiving their right to a Medicare EHR Incentive Program payment for this year.

Payment Amount Appeals	
Reason for Appeal	**Documentation Needed**
Eligible Professional payment amount (pediatrician only)	Provide the patient volume numbers for the reported 90-day period that should have been reported on the original Wisconsin Medicaid EHR Incentive Program application.
Eligible Hospital payment amount	Upload the Eligible Hospital's Medicare and Medicaid Cost Reports for the last four years.

Eligibility

Topic #12038

Eligible Professionals for EHR Incentive Program

To be eligible to participate in the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program, an Eligible Professional must be enrolled in Wisconsin Medicaid as one of the following:

- Advanced practice nurse prescriber with psychiatric specialty.
- Dentist.
- Nurse midwife.
- Nurse practitioner.
- Physician.
- PAs (physician assistants). Only PAs practicing in an FQHC (federally qualified health center) or RHC (rural health clinic) are considered Eligible Professionals.

Note: Under the federal law, only PAs practicing in an FQHC or RHC that is so led by a PA are considered Eligible Professionals. "So led" is defined in the federal regulation as one of the following:

- When a PA is the primary provider in a clinic.
- When a PA is a clinical or medical director at a clinical site of practice.
- When a PA is an owner of an RHC.

Eligible Professionals who are able to demonstrate that they funded the acquisition of the CEHRT (Certified Electronic Health Record Technology) they are using without reimbursement from an Eligible Hospital and provide more than 90 percent of their services in POS (place of service) 21 (Inpatient Hospital) or 23 (Emergency Room — Hospital) are eligible to participate in the Wisconsin Medicaid EHR Incentive Program. Hospital-based Eligible Professionals are required to upload one of the following documents as part of the application process:

- Receipt or proof of purchase detailing the CEHRT, including the vendor, product, and version number.
- Contract or lease detailing the CEHRT, including the vendor, product, and version number.

Financial Information

Topic #12120

835 Health Care Claim Payment/Advice Transaction

To assist trading partners in identifying Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payments received for an Eligible Professional or organizations on the 835 (835 Health Care Claim Payment/Advice) transaction, the NPI (National Provider Identifier) of the Eligible Professional approved to receive the Wisconsin Medicaid EHR Incentive Program payment will appear in segment PLB01 of the 2110 Loop. The PLB03-1 segment identifies the adjustment reason code. A code of LS will represent a positive incentive payment while a code of WO will represent a recovery of a previously paid incentive payment. The PLB04 segment will represent the monetary amount that is either paid or recouped based on the Adjustment Reason Code displayed in PLB03-1.

Topic #12118

Electronic Funds Transfer

Eligible Professionals who assign payments to themselves as individuals may elect to receive paper checks but are encouraged to set up an EFT (electronic funds transfer). EFTs allow ForwardHealth to directly deposit payments into the group's or Eligible Professional's designated bank account for a more efficient delivery of payments. An EFT is secure, eliminates paper, and reduces the uncertainty of possible delays in mail delivery.

Eligible Professionals that assign payments to an organization or clinic must supply the organization's EFT number. Organizations receiving payment from an Eligible Professional may only receive incentive payments through their existing EFT account.

Refer to the Electronic Funds Transfer User Guide on the Portal User Guides page of the Portal for information on EFT enrollment.

Topic #12117

Example of a Six-Year Payment Schedule for an Eligible Professional

Eligible Professionals who complete all the requirements for each applicable payment year will receive incentive payments in lump sums, as listed in the following table. Eligible Professionals may begin registering for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program beginning in 2011 and up until 2016.

Calendar Year	**Wisconsin Medicaid Eligible Professionals***					
	2011	2012	2013	2014	2015	2016
2011	$21,250	—	—	—	—	—
2012	$8,500	$21,250	—	—	—	—
2013	$8,500	$8,500	$21,250	—	—	—
2014	$8,500	$8,500	$8,500	$21,250	—	—

2015	$8,500	$8,500	$8,500	$8,500	$21,250	—
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017	—	$8,500	$8,500	$8,500	$8,500	$8,500
2018	—	—	$8,500	$8,500	$8,500	$8,500
2019	—	—	—	$8,500	$8,500	$8,500
2020	—	—	—	—	$8,500	$8,500
2021	—	—	—	—	—	$8,500
Total	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

*Pediatricians with a minimum of 20 percent eligible member patient volume, but less than 30 percent eligible member patient volume will receive two-thirds of the incentive payment amounts. Eligible pediatricians will receive $14,167 in their first payment year, $5,667 in their second payment year, and $42,500 in their third through sixth payment years.

Topic #12105

Incentive Payment Information

Eligible Professionals who meet all of the requirements will receive an incentive payment once per calendar year. Eligible Professionals must assign payment to either themselves or their organization's federal TIN (tax identification number).

Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payments for Eligible Professionals may only be assigned to either the Eligible Professional themselves or the group practice assigned for the pay-to address on the Wisconsin Medicaid provider file. Eligible Professionals should ensure that the most current group practice is assigned for the pay-to address. Eligible Professionals can check this information via their ForwardHealth Portal Account in the "Demographic" section.

Topic #12119

Remittance Advice

Financial Transactions Section

Eligible Professionals and Eligible Hospitals will see the following information under the "Non-Claim Specific Payouts to Payee" section within the financial transactions page of the TXT (text) version of the RA (Remittance Advice) as well as within Section 130 of the CSV (comma-separated value) downloadable file:

- All Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payments will appear under the "Non-Claim Specific Payouts to Payee" section of the RA.
- Amounts identified with the Reason Code 0247 will designate the amount as a Wisconsin Medicaid EHR Incentive Program payment.
- Amounts identified with the Reason Code 0248 will designate the amount as a Wisconsin Medicaid EHR Incentive Program positive adjustment.
- Payments reported in this section are processed and mean the same as any other ForwardHealth payment identified within this section.
- A new field has been added, called "Related Provider ID," to identify the NPI (National Provider Identifier) of the individual Eligible Professional approved to receive the Wisconsin Medicaid EHR Incentive Program payment.

Eligible Professionals and Eligible Hospitals will see the following information on the "Accounts Receivable" section within the Financial Transactions page of the TXT version of the RA as well as within Section 150 of the CSV downloadable file:

- If a negative adjusting entry is required to adjust the original Wisconsin Medicaid EHR Incentive Program incentive payment issued, an Accounts Receivable transaction will be generated to initiate the adjusting entry. All Wisconsin Medicaid EHR Incentive Program payment adjustments will be identified with the Reason Code 0265 (EHR Payment Adjustment). The Wisconsin Medicaid EHR Incentive Program payments are subject to recoupment as a result of any monies owed to ForwardHealth.
- The Wisconsin Medicaid EHR Incentive Program payment adjustments are processed and report on the RA as they do today under the Accounts Receivable section.

Summary Section

The Earnings Data section on the Summary section of the TXT version of the RA and the Sections 160 (Summary Net Payments) and Section 180 (Summary Net Earnings) of the CSV downloadable file will include the Wisconsin Medicaid EHR Incentive Program payments and adjustments reported on the Financial Transactions section. The process for calculating and reporting the net payments and earnings for the Summary section has not changed.

Meaningful Use of Certified EHR Technology

Topic #13357

Definition of Meaningful Use

The Medicare and Medicaid EHR (Electronic Health Record) Incentive Programs provide a financial incentive for the meaningful use of certified technology to achieve health and efficiency goals. By implementing and using EHR systems, Eligible Professionals can also expect benefits beyond financial incentives, such as reduction of clerical errors, immediate availability of records and data, clinical decision support, and e-prescribing and refill automation.

The American Recovery and Reinvestment Act of 2009 specifies three main components of meaningful use:

- The use of a certified EHR in a meaningful manner, such as e-prescribing.
- The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
- The use of certified EHR technology to submit clinical quality and other measures.

In short, meaningful use means Eligible Professionals need to demonstrate that they are using EHR technology in ways that can be measured in quality and quantity.

Topic #13358

Electronic Health Record Reporting Period for Meaningful Use

The EHR (Electronic Health Record) Reporting Period is defined as the timeframe when Eligible Professionals report meaningful use to the Wisconsin Medicaid EHR Incentive Program. The EHR Reporting Period years are defined as:

- First year: The Eligible Professional must be able to show meaningful use for a 90-day timeframe that falls within the Calendar Year that the Eligible Professional is applying for a Wisconsin Medicaid EHR Incentive Program payment. For example, if an Eligible Professional is applying for the 2012 Wisconsin Medicaid EHR Incentive Program payment, the entire 90-day reporting period must fall in Calendar Year 2012.
- Subsequent years: The Eligible Professional must be able to show meaningful use for the entire Calendar Year for which the Eligible Professional is applying for the Wisconsin Medicaid EHR Incentive Program payment. For example, if an Eligible Professional is applying for the 2013 Wisconsin Medicaid EHR Incentive Program payment, the reporting period must be January 1, 2013, through December 31, 2013.

Topic #13417

Eligible Professional Stage 1 Meaningful Use Supporting Documentation

The table below contains examples of supporting documentation an Eligible Professional (EP) would be expected to provide if selected for an audit of an application submitted for the Wisconsin Medicaid EHR Incentive Program under stage 1 meaningful use.

Example #	Requirement	Measure	Examples of Supporting Documentation
1	Must report and meet the required threshold/answers for all General Requirements and Core Measures	EPGMU 01-02 EPCMU 01-15	• Meaningful Use Reports/Dashboard produced by Certified EHR Technology (CEHRT) • Documentation on how the attestations were created, specifically how the numerator/ denominators were calculated, including rationale taken into account for inclusion/exclusion of data
2	EPGMU 01: Percent of CEHRT Use	Must have 50 percent or more of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology	• List of total encounters with detail including date, patient identifier, payer, and rendering provider • List of encounters with CEHRT, with detail on location and CEHRT used
3	EPGMU 02: Unique Patients in CEHRT	Must have 80 percent or more of their unique patient data in the certified EHR during the EHR reporting period	• List of all unique patients with indication of whether in CEHRT. If practicing at multiple locations, indicate which patients seen in what location
4	EPCMU 01: Computerized physician order entry (CPOE)	Must have at least one medication order entered using CPOE for more than 30 percent of all unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period	• Access to a random sampling of patient records • Rationale for exclusion/ inclusion of patient records
5	EPCMU 02: Drug-drug and drug-allergy interaction checks	Must have enabled functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period	• Audit log showing it is enabled for this functionality with time/date stamp
6	EPCMU 03: Maintain an up-to-date problem list of current and active diagnoses	Must have at least one entry (or an indication that no problems are known for the patient) recorded as structured data for more than 80 percent of all unique patients seen by the EP during the EHR reporting period	• Access to a random sampling of patient records
7	EPCMU 04: E-Prescribing (eRx)	Must have used the certified EHR technology to transmit prescriptions electronically for more than 40 percent of all permissible prescriptions written by the EP during the EHR reporting period	• Access to a random sampling of patient records • Rationale for exclusion/inclusion of patient records • Rationale for exclusion/inclusion of prescriptions
8	EPCMU 05: Maintain	Must have at least one active	• Access to a random sampling of

	active medication list	medication entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data for more than 80 percent of all unique patients seen by the EP during the EHR reporting period	patient records • Rationale for exclusion/inclusion of patient records
9	EPCMU 06: Maintain active medication allergy list	Must have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data for more than 80 percent of all unique patients seen by the EP during the EHR reporting period	• Access to a random sampling of patient records
10	EPCMU 07: Record demographics	Must have demographics recorded as structured data for more than 50 percent of all unique patients seen by the EP during the EHR reporting period	• Access to a random sampling of patient records
11	EPCMU 08: Record and chart changes in vital signs	Must have height, weight, and blood pressure recorded as structured data for more than 50 percent of all unique patients age 2 and over seen by the EP during the EHR reporting period	• Access to a random sampling of patient records • Rationale for exclusion/ inclusion of patient records
12	EPCMU 09: Record smoking status for patients 13 years or older	Must have smoking status recorded as structured data for more than 50 percent of all unique patients 13 years old or older seen by the EP during the EHR reporting period	• Access to a random sampling of patient records • Rationale for exclusion/ inclusion of patient records
13	EPCMU 10: Report ambulatory clinical quality measures to CMS/states	Must successfully report to Wisconsin the ambulatory clinical quality measures selected by CMS in the manner specified by Wisconsin	• Audit log showing the enabling of this functionality with time/date stamp
14	EPCMU 11: Implement one clinical decision support rule	Must implement one clinical decision support rule	• Rationale for clinical decision support rule implemented • Audit log showing the enabling of this functionality with time/date stamp
15	EPCMU 12: Provide patients with an electronic copy of their health information upon request	Provide an electronic copy of health information to more than 50% of patients who request it within 3 business days.	• EP Policy and Procedure documentation • Rationale for exclusion/inclusion of patient records
16	EPCMU 13: Provide clinical summaries for patients for each office visit	Must have provided clinical summaries to patients for more than 50 percent of all office visits within 3 business days.	• Rationale for exclusion/ inclusion of patient records • Sample of Clinical Summary
17	EPCMU 14: Capability to	Must have performed at least one	• Detail of exchange of key clinical

	exchange key clinical information among providers of care and patient-authorized entities electronically	test of CEHRT's capacity to electronically exchange key clinical information.	information including, but not limited to: date, time, entity with which exchange took place (including contact information), and method of transportation for the exchange (include information on HIE used if applicable)
18	EPCMU 15: Protect electronic health information	Must conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), implement security updates as necessary, and correct identified security deficiencies as part of its risk management process.	• Detail on security risk analysis including, but not limited to: approach for assessment, results of the assessment, indication of who performed the assessment • Detail on security update performed as a result of the security risk analysis including, but not limited to: update made, date made
19	Must report and meet the required threshold/answers for 5 of the 10 Menu Measures with at least one measure being classified as a public health measure (EPMMU 09 or EPMMU 10)	EPMMU 01 -EPMMU 10	• Meaningful Use Reports/ Dashboard produced by CEHRT • Documentation on how the attestations were created, specifically how the numerator/denominators were calculated, including rationale taken into account for inclusion/exclusion of data
20	EPMMU 01: Drug-formulary checks	Must have enabled Drug- formulary check functionality and have access to at least one internal or external formulary for the entire EHR reporting period	• Audit log showing the enabling of this functionality with time/date stamp
21	EPMMU 02: Incorporate clinical lab test results as structured data	Must have incorporated in CEHRT as structured data, more than 40 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format	• Access to a random sampling of patient records
22	EPMMU 03: Generate lists of patients by specific conditions	Must generate at least one report listing patients of the EP with a specific condition	• Rationale/reason for the list being generated with detail on the specific condition addressed • Rationale for exclusion/inclusion of patient records
23	EPMMU 04: Send reminders to patients per patient preference for preventive/follow up care	Must have sent an appropriate reminder during the EHR reporting period to more than 20 percent of all patients 65 years or older or 5 years old or younger.	• Access to a random sampling of patient records • Rationale for exclusion/ inclusion of patient records
24	EPMMU 05: Provide	Must have provided timely	• Access to a random sampling of

	patients with timely electronic access to their health information	(available to the patient within four business days of being updated in the certified EHR technology) electronic access to health information (subject to the EP's discretion to withhold certain information) for at least 10 percent of all unique patients seen by the EP during the EHR reporting period	patient records • Rationale for exclusion/ inclusion of patient records
25	EPMMU 06: Use CEHRT to identify patient-specific education resources and provide to patient, if appropriate	Must have provided patient-specific education resources to more than 10 percent of all unique patients seen by the EP during the EHR reporting period	• Documentation of patient-specific education resources that are provided to patients
26	EPMMU 07: Medication reconciliation	Must perform medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP during the EHR reporting period	• Access to a random sampling of patient records • Rationale for exclusion/ inclusion of patient records
27	EPMMU 08: Summary of care record for each transition of care/ referrals	Must provide a summary of care record for more than 50 percent of transitions of care and referrals of patients to another setting of care or provider of care during the EHR reporting period	• Access to a random sampling of patient records • Rationale for exclusion/ inclusion of patient records
28	EPMMU 09: Capability to submit electronic data to immunization registries/systems*	Must have performed at least one test of CEHRT's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically).	• Detail on test date and time
29	EPMMU 10: Capability to provide electronic syndromic surveillance data to public health agencies*	Performed at least one test of CEHRT's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically).	• Detail on test date and time • Wisconsin Public Health Letter qualifying EP for exclusion

Topic #13377

Meaningful Use Criteria Overview

CMS (Centers for Medicare and Medicaid Services) has split the meaningful use criteria into three stages that will be rolled out over the course of the next five years. Currently, the stages are identified as follows:

- Stage 1 sets the baseline for electronic data capture and information sharing.
- Stages 2 and 3 will continue to expand on this baseline and be developed through future rule making.

Requirements for Stage 1 of Meaningful Use

The requirements for stage 1 of meaningful use include both a "core set" and a "menu set" of objectives that are specific to Eligible Professionals. There are a total of 23 meaningful use objectives. To qualify for a Wisconsin Medicaid EHR Incentive Program payment, 18 of the 23 meaningful use objectives must be met. Of the 23 objectives, there are 13 required "core set" objectives that must be met. The remaining five "menu set" objectives may be chosen from a list of ten menu set objectives, of which two are Public Health measures. In addition to reporting 18 meaningful use objectives, Eligible Professionals must report from a table of 44 CQMs (clinical quality measures), which include three Core or three Alternate Core and 38 additional CQMs.

Some meaningful use objectives are not applicable to every Eligible Professional's clinical practice; therefore, no patients or actions would be eligible for the measure denominator. In these cases, the Eligible Professional would be excluded from having to meet that measure. For example, core measure nine of 13 is to "Record smoking status for patients 13 years old or older." An Eligible Professional who does not see patients 13 years or older may select the exclusion to this measure.

Eligible Professionals should refer to the CMS Web page for a complete table of contents of all core set and menu set objectives. Each objective contains the following information:

- The definition of the objective.
- How to measure the objective.
- Any applicable exclusions.

Additional information may also be included on this Web page regarding the following:

- Term definitions.
- Attestation requirements.
- Any other additional information related to the objective.
- Frequently asked questions.

Clinical Quality Measures

Clinical quality measures are tools that help measure or quantify health care processes, outcomes, patient perceptions, organizational structures, and systems that are associated with the ability to provide high-quality health care. To demonstrate meaningful use successfully, Eligible Professionals must report CQMs. Eligible Professionals must report on at least six measures: three from the Core Set of Clinical Quality Measures or from the Alternate Core Set if unable to report on any of the Core Set, and three from the 38 Additional Set of Clinical Quality Measures.

Eligible Professionals should refer to the CMS Web page for complete information on reporting clinical quality measures.

Public Health Meaningful Use Measures

Two of the 10 stage 1 meaningful use menu set requirements for Eligible Professionals specify electronic transmission of the following data to Public Health:

- Immunizations.
- Syndromic surveillance.

Eligible Professionals must meet five of the menu set requirements, one of which must be a public health requirement. If an Eligible Professional can be excluded from the requirements of both public health measures, the Eligible Professional may only select one of the public health measures, but not both, for attestation. Selecting both for an exclusion will not be permitted in this scenario. If an Eligible Professional can meet the requirements of one public health measure but can be excluded from the other, both measures may be selected for attestation.

The DPH (Division of Public Health) Wisconsin Immunization Program is presently able to conduct testing with Eligible Professionals for data submission of immunizations. The measure for validation of stage 1 public health meaningful use requires only that a single test be conducted. If multiple Eligible Professionals are using the same certified EHR technology in a shared physical setting, the test only has to be conducted once for the physical setting, not once for each Eligible Professional at the location. The Eligible Professional or location should institute ongoing data submission if the Wisconsin Immunization Program acknowledges a successful test. If the test is unsuccessful, the Eligible Professional or Eligible Professionals at the location will still satisfy the requirements of this measure for meaningful use. The Wisconsin Immunization Program will continue to work with the Eligible Professional or location to achieve a successful test to enable ongoing data submission.

The DPH is not presently accepting the submission of syndromic surveillance data from Eligible Professionals and will not be capable of accepting this data or testing with Eligible Professionals in 2012. An Eligible Professional may request a letter from DPH indicating DPH's lack of capability to accept syndromic surveillance data submissions. If the Eligible Professional selects this measure, DPH recommends the Eligible Professional follow the attestation instructions and guidance from CMS for claiming an exclusion. Deciding to attest on this measure assumes the Eligible Professional could also take an exclusion on the immunization data submission and has selected this public health measure for exclusion instead; or has selected both measures for attestation and was able to conduct a test submission of immunization data.

Eligible Professionals should refer to the Wisconsin DHS Web site for more information regarding Public Health meaningful use.

Responses for Meaningful Use Measures

Eligible Professionals will have three different types of responses to meaningful use measures:

- Yes or No.
- Attest to exclusions (any measure not applicable to the Eligible Professional's practice).
- Numerators and Denominators.

Numerators and Denominators

When entering percentage-based measures, the calculation to determine the meaningful use numerator and denominator will vary by measure. Eligible Professionals should refer to CMS Stage 1 EHR Meaningful Use Specification Sheets for Eligible Professionals for clear definition of meaningful use numerator and denominator prior to completing the Wisconsin Medicaid EHR Incentive Program application. Meaningful use numerators and denominators include the number of patients relevant as defined in the Specification Sheets and not just Medicare and Medicaid patients.

Eligible Professionals should refer to the CMS Stage 1 EHR Meaningful Use Specification Sheets.

Eligible Professionals should refer to their EHR system for meaningful use denominators to be entered into the Wisconsin Medicaid EHR Incentive Program application. Eligible Professionals should note that each EHR system varies.

Meaningful Use Supporting Documentation

All information is subject to audit at any time and must be maintained by Eligible Professionals for a period of six years. If selected

for an audit, the applicant must be able to supply supporting documentation.

Topic #13397

Stages of Meaningful Use and Payment Years

The table below demonstrates what stage of meaningful use must be reported based upon the first year an Eligible Professional began participation in the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. Eligible Professionals should note that they do not need to participate in consecutive Program Years.

First Year of Participation	Program Year				
	2011	2012	2013	2014	2015
2011	AIU (adoption, implementation or upgrade)/Stage 1 MU (meaningful use)	Stage 1	Stage 2	Stage 2	TBD
2012		AIU/Stage 1 MU	Stage 1	Stage 2	TBD
2013			AIU/Stage 1 MU	Stage 1	TBD
2014				AIU/Stage 1 MU	TBD

Patient Volume

Topic #12098

Eligible Member Patient Volume

The federal law 42 CFR s. 495.306(c)(1) stipulates that only certain services rendered to certain members that are reimbursed with Medicaid (Title XIX) funds may be counted towards eligible member patient volume requirements. The Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program defines eligible members as those members enrolled in the programs listed here.

Eligible Professionals using the eligible member patient volume method must meet a minimum patient encounter volume threshold of one of the following:

- At least 30 percent of their patient volume attributed to eligible members over a continuous 90-day period in the calendar year preceding the payment year.
- Pediatricians will be considered eligible if 20 percent of their patient encounter volume is attributable to eligible members but will receive two-thirds of the incentive amounts. If a pediatrician's patient encounter volume is 30 percent or higher, the incentive payments are the same as any other Eligible Professional.

Note: Eligible Professionals should note that the Wisconsin Medicaid EHR Incentive Program will not round up to meet the minimum patient volume threshold. All patient volumes reported that are below 30 percent (including those at or below 29.99 percent) will be deemed ineligible.

An eligible member patient encounter is defined as any services rendered on any one day to an individual enrolled in a Medicaid program. The Wisconsin Medicaid EHR Incentive Program will consider a claim paid at $0 or more for services rendered on any one day to an individual enrolled in a Medicaid program to be an eligible member patient encounter.

Multiple Eligible Professionals may count an encounter for the same individual. For example, it may be common for a PA (physician assistant) or nurse practitioner and physician to provide services to a patient during an encounter on the same DOS (date of service). It is acceptable in these and similar circumstances to count the same encounter for multiple Eligible Professionals for purposes of calculating each Eligible Professional's patient volume. The encounters must take place within the scope of practice for each of the Eligible Professionals.

Eligible Professionals may be unable to distinguish between some eligible members and some non-eligible members when determining their patient volume. The Wisconsin Medicaid EHR Incentive Program only considers services provided to members that are reimbursed with funding directly from Medicaid (Title XIX) as a patient encounter. Eligible Professionals may be unable to determine where funding for eligible members comes from, so in order to assist Eligible Professionals in determining their eligible patient encounters, the Wisconsin Medicaid EHR Incentive Program will calculate a standard deduction. The standard deduction for 2013 is 8.01 percent.

To figure out the eligible member patient encounters, the Eligible Professional must multiply the total eligible member encounter patient volume by a factor of (1 - .0801) or 0.9199 and then divide that number by the total eligible member patient encounter volume. The final number should be rounded to the nearest whole number (i.e., .01 through .49 should be rounded down and .50 through .99 should be rounded up to the nearest number.)

Eligible Professionals using the eligible member patient volume method may elect to calculate patient volume at the individual or group practice level. If an Eligible Professional calculates his or her patient encounter volume based on a group practice level, the entire group practice's patient encounter volume must be included. This includes the services rendered by all providers within the

group practice, regardless of provider type or eligibility status for the Wisconsin Medicaid EHR Incentive Program. Additionally, all Eligible Professionals included in the group practice who register for the Wisconsin Medicaid EHR Incentive Program must also register using the group practice patient volume.

A group practice is defined by how a group practice enumerates its business using NPIs (National Provider Identifiers). When calculating a group practice patient volume, the group practice patient volume methodology can only be used if all of the following conditions are satisfied:

- The eligible members included in the group practice patient volume calculation were provided services during the 90-day period that the group practice is attesting (for the first year).
- There is an auditable data source to support a group practice's patient volume determination.
- All Eligible Professionals in the group practice use the same methodology for the payment year.
- The group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way.
- If an Eligible Professional works inside and outside the group practice, the patient volume calculation may only include those encounters associated with the group practice and not individual encounters outside the group practice.

Note: Eligible Professionals should note that whether they calculate their eligible member patient encounter volume as a group practice or as an individual will not affect how the incentive payments are distributed. For example, an Eligible Professional may calculate their eligible member patient volume at an individual level and assign payment to their group practice. Conversely, an Eligible Professional may calculate their eligible member patient volume at a group practice level and assign payment to themselves.

Eligible Professionals calculating group practice patient volume under the eligible member patient volume must meet a minimum of at least 30 percent of their patient volume attributed to eligible members. The standard deduction must be applied to the total (in-state) eligible member-only patient encounters of the group and rounded to the nearest whole number prior to entry in the Wisconsin EHR Incentive Program application.

Topic #12101

Example of Calculating Group Practice Patient Volume

Eligible Professionals must have at least 30 percent of their patient volume encounters attributed to eligible members. When electing to use group practice patient volume, the entire practice's patient volume must be included. This includes the services rendered by all Eligible Professionals within the group practice, regardless of provider type or eligibility status for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. Groups are defined by how their businesses are enumerated under their NPI (National Provider Identifier).

The following is an example of calculating group practice volume for the purpose of establishing eligibility for the Wisconsin Medicaid EHR Incentive Program.

Eligible Based on Provider Type	Provider Type	Total Encounters (Eligible Members/Total)	Percentage of Eligible Member Encounters
Yes	Physician	80/200	40 percent
Yes	Nurse Practitioner	50/100	50 percent
Yes	Physician	0/100	0 percent
No	Registered Nurse	150/200	75 percent
No	Pharmacist	80/100	80 percent
Yes	Physician	30/300	10 percent

Yes	Dentist	5/100	5 percent
Yes	Dentist	60/200	30 percent

In this scenario, there are 1300 encounters in the selected 90-day period. Of the 1300 encounters, 455 are attributable to eligible members, or 35 percent. The next step is to apply the standard deduction (1 - .0801 = 0.9199) to the number of eligible members.

455 * 0.9199 = 418.554

That number is divided by the total number of encounters in the selected 90-day period, or 1300.

418.554 / 1300 = 0.321 or 32.1 percent

Therefore, the group practice patient volume is 32.1 percent, which is rounded to the nearest whole number of 32 percent, and is eligible for the Wisconsin Medicaid EHR Incentive Program.

Eligible Professionals should note that even though one dentist's eligible member encounter percentage was only 5 percent and one physician's eligible member encounter percentage was 10 percent, when included in the group practice patient volume, both are eligible for the program when registering with the group practice patient volume. The physician whose eligible member encounter percentage is zero is not eligible for the program because he or she did not render services to at least one eligible member.

Topic #12100

Example of Calculating Individual Patient Volume

Eligible Professionals must have at least 30 percent (except pediatricians, who must have at least 20 percent) of their patient volume attributed to eligible members. For example, if an Eligible Professional calculates his or her total eligible member patient encounter volume of 33 out of a total patient encounter volume of 75, the eligible member patient volume is 44 percent.

Eligible Professionals may be unable to distinguish between some eligible members and some non-eligible members when determining their patient volume. The Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program only considers services provided to members who are reimbursed with funding directly from Medicaid (Title XIX) as a patient encounter. Eligible Professionals may be unable to determine where funding for eligible members comes from, so in order to assist Eligible Professionals in determining their eligible patient encounters, the Wisconsin Medicaid EHR Incentive Program will calculate a standard deduction. The standard deduction for 2013 is 8.01 percent.

To figure out the eligible member patient encounters, Eligible Professionals must multiply their total eligible member encounter patient volume by a factor of (1 - .0801) or 0.9199 and then divide that number by their total eligible member patient encounter volume.

Standard Deduction Calculation

Total eligible member patient encounters during any 90-day continuous period * 0.9199

---------- * 100

Total patient encounters, regardless of payer over that same 90-day continuous period

-Or-

33 * 0.9199

---------- * 100 = 40.47 percent

75

So the final eligible member patient encounter volume is 30.35 encounters out of 75 total, or 40.47 percent, rounded to the nearest whole number, 40 percent.

Therefore, 40 percent of the Eligible Professional's patient volume is eligible members and the Eligible Professional fulfills the patient volume requirement for the Wisconsin Medicaid EHR Incentive Program. Eligible Professionals should note that the Wisconsin Medicaid EHR Incentive Program will not round up to meet the minimum patient volume threshold. All patient volumes reported that are below 30 percent (including those at or below 29.99 percent) will be deemed ineligible.

Topic #12097

Members Who May Be Counted When Determining Patient Volume

Most members enrolled in the programs listed below are considered eligible members and may be counted when determining patient encounters and patient volume:

- Wisconsin Medicaid.
- BadgerCare Plus Standard Plan.
- BadgerCare Plus Benchmark Plan.
- BadgerCare Plus Core Plan.
- BadgerCare Plus Express Enrollment for Pregnant Women.
- Alien Emergency Service Only.
- TB-Only (Tuberculosis-Related Service Only) Benefit.
- Family Planning Only Services.

Note: There are certain members enrolled in these programs or certain services provided to eligible members that may be included in the patient volume, which is the reason for the standard deduction.

Topic #12099

Needy Individual Patient Volume

The federal law stipulates that only certain services rendered to certain individuals may be counted towards the needy individual patient volume requirements. The Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program defines needy individuals as those listed here as well as those who are provided uncompensated care by the provider, or individuals provided services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

Only Eligible Professionals, including pediatricians, practicing predominantly in an FQHC (Federally Qualified Health Center) or RHC (Rural Health Clinic) may use the Needy Individual Patient Volume method. An Eligible Professional is defined as practicing predominantly in a FQHC or RHC if more than 50 percent of the Eligible Professional's encounters occur in an FQHC or RHC during a six-month period in the most recent calendar year or in the most recent 12 months prior to attestation.

Eligible Professionals using the Needy Individual Patient Volume method must meet a minimum of 30 percent needy individual patient volume threshold. Needy Individual Patient Volume encounters consist of the following:

- Services rendered on any one day to an individual where Medicaid or BadgerCare Plus paid all or part of the service including copayments or any other cost-sharing.
- Services rendered on any one day to an individual where Children's Health Insurance Program under Title XXI paid for part or all of the service.
- Services rendered on any one day to an individual furnished by the provider as uncompensated care.
- Services rendered on any one day to an individual furnished at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

Eligible Professionals using the Needy Individual Patient Volume method may elect to calculate patient volume at an individual or a group practice level. If an Eligible Professional calculates his or her patient encounter volume based on a group practice, the entire group practice's patient volume must be included. This includes the services rendered by all providers within the group practice, regardless of provider type or eligibility status for the Wisconsin Medicaid EHR Incentive Program. Additionally, all Eligible Professionals included in the group practice who register for the Wisconsin Medicaid EHR Incentive Program must also register using the group practice patient volume.

A group practice is defined by how a group practice enumerates its business using NPIs (National Provider Identifiers). When calculating a group practice patient volume, the group practice patient volume methodology can only be used if all of the following conditions are satisfied:

- The eligible members included in the group practice patient volume calculation were provided services during the 90-day period that the organization is attesting (for the first year).
- There is an auditable data source to support a group practice's patient volume determination.
- All Eligible Professionals in the group practice use the same methodology for the payment year.
- The group practice uses the entire group practice's patient volume and does not limit patient volume in any way.
- If an Eligible Professional works inside and outside the group practice, the patient volume calculation may only include those encounters associated with the group practice and not individual encounters outside the group practice.

Note: Eligible Professionals should note that whether they calculate their needy individual patient encounter volume as a group practice or as an individual will not affect how the incentive payments are distributed. For example, an Eligible Professional may calculate his or her needy individual patient volume at an individual level and assign payment to the group practice. Conversely, an Eligible Professional may calculate his or her needy individual patient volume at a group practice level and assign payment to him- or herself.

Eligible Professionals calculating group patient volume under the needy individual patient volume must meet a minimum of at least 30 percent of their patient volume attributed to needy individuals. The standard deduction must be applied to the total (in-state) eligible member-only patient encounters of the organization and rounded to the nearest whole number prior to entry in the Wisconsin EHR Incentive Program application.

Topic #12078

Patient Volume Requirements and Calculations

In addition to other EHR (Electronic Health Record) Incentive Program requirements, Eligible Professionals must meet patient volume thresholds over the course of a 90-day period.

Eligible Professionals are required to select one of the following patient volume reporting periods:

- Calendar year preceding payment year.
- Twelve months preceding attestation date.

Note: The attestation date is defined as the day when the application is electronically signed and submitted for the first time in the Program Year or the last day of the Program Year if applying during the grace period.

An Eligible Professional cannot calculate patient volume by including patient encounters that occur during the 90-day grace period following the Program Year. For example, an Eligible Professional who applies for Program Year 2013 participation cannot include patient encounters occurring after December 31, 2013.

An Eligible Professional cannot use the same or overlapping patient volume periods for future Program Year applications. For example, an Eligible Professional uses January 1, 2013, through March 31, 2013, for Program Year 2013. In Program Year 2014, the Eligible Professional cannot use January 1, 2013, through March 31, 2013, or any overlapping period (i.e., February 1, 2013, through April 30, 2013).

When reporting patient volume, Eligible Professionals will designate which practice locations are using certified EHR technology and enter the relevant patient encounter data needed to determine eligibility. Patient encounter data will be entered in three parts for each practice location:

- The total (in-state) eligible member-only patient encounter volume over the previously determined continuous 90-day reporting period.
- The total (regardless of state) eligible member-only patient encounter volume over the previously determined continuous 90-day reporting period.
- The total patient encounter volume (regardless of state or payer) over the previously determined continuous 90-day reporting period.

When attesting to Wisconsin Medicaid EHR Incentive Program patient volume requirements, there are two methods by which an Eligible Professional may calculate patient volume.

- Eligible member patient volume.
- Needy individual patient volume.

Each patient volume method contains its own unique requirements; however, only Eligible Professionals practicing in an FQHC (federally qualified health center) or RHC (rural health clinic) may use the needy individual patient volume method.

Registration and Applying

Topic #12057

Individuals Applying for the EHR Incentive Program

A secure Provider account on the ForwardHealth Portal is required to apply for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. All applications must be completed via a secure Provider Portal account.

An Eligible Professional applying as an individual needs to follow the process below when applying for the Wisconsin Medicaid EHR Incentive Program:

- The Eligible Professional needs to first log in to the Portal. If the Eligible Professional does not have a Portal account, he or she needs to obtain one. The Eligible Professional should refer to the Account User Guide on the Portal User Guides page of the Provider area of the Portal for more information on obtaining a Portal account.
- The Eligible Professional needs to click on the Wisconsin Medicaid EHR Incentive Program link in the Quick Link box.
- The Eligible Professional will have to designate payment to either him- or herself or to the organization.

Topic #12040

Organizations Applying for the EHR Incentive Program on Behalf of Eligible Professionals

A secure Provider Portal account is required to apply for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. All applications must be completed via a secure Provider ForwardHealth Portal account.

Organizations applying on behalf of Eligible Professionals need to follow the process below when applying for the Wisconsin Medicaid EHR Incentive Program:

- The organization needs to first log in to the Portal. The organization only needs one Portal account to apply for all Eligible Professionals assigning payment to their organization and associated with the organization's federal TIN (tax identification number). If the organization does not have a Portal account, it needs to obtain one. Refer to the Account User Guide on the Portal User Guides page of the Provider area of the Portal for more information on obtaining a Portal account.
- Portal Administrators will automatically have access to the Wisconsin Medicaid EHR Incentive Program application. Organizations may assign the new "EHR Incentive" role to a clerk to conduct all Wisconsin Medicaid EHR Incentive Program business.
- The organization may access the EHR Incentive Program application by clicking on the Wisconsin Medicaid EHR Incentive Program link in the Quick Link box.
- The organization will see a list of all Eligible Professionals that are associated with the organization's TIN. The organization will have to submit a separate application for each Eligible Professional associated with their TIN. Organizations should note that once an application has begun for an Eligible Professional, only the Portal account used to begin the application can access that Eligible Professional's application.

Topic #12039

Registration for the EHR Incentive Program with CMS

All Eligible Professionals are required to first register at the R&A (Medicare and Medicaid Electonic Health Record Incentive Program Registration and Attestation System) Web site. A step-by-step walkthrough of the R&A registration process for Eligible Professionals is also available online.

After an Eligible Professional successfully registers on the R&A, CMS (Centers for Medicare and Medicaid Services) will process the registration and send the file to the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. After receipt of the file, the Wisconsin Medicaid EHR Incentive Program will enter all relevant information into the ForwardHealth system. Eligible Professionals must wait two full business days before beginning the application for the Wisconsin Medicaid EHR Incentive Program to allow for this process.

Topic #12058

Required Information When Starting the EHR Incentive Program Application

Eligible Professionals will be required to supply specific information when completing the EHR (Electronic Health Record) Incentive Program application. Eligible Professionals do not have to complete the entire application in one session. The application will allow users to save the information entered and return later to complete the application.

Eligible Professionals should have the following information available when beginning the application:

- Information submitted to the R&A (Medicare and Medicaid Electronic Health Record Incentive Program Registration and Attestation System). Eligible Professionals will need to confirm all of this information during the initial application phases.
- Contact name, telephone number, and e-mail address of the authorized preparer of the Eligible Professional's application, if not the Eligible Professional.
- Information regarding whether or not the Eligible Professional applying to the Wisconsin Medicaid EHR Incentive Program has any sanctions or pending sanctions with the Medicare or Medicaid programs and is licensed to practice in all states in which services are rendered.
- The CMS (Centers for Medicare and Medicaid Services) EHR certification ID for the certified EHR technology the Eligible Professional already has or is contractually obligated to acquire. For more information on approved EHR technology, Eligible Professionals should refer to the ONC (Office of the National Coordinator for Health Information Technology)-certified EHR product list.
- Required Patient Volume Data:
    - The total in-state eligible member patient encounter volume over the previously determined continuous 90-day reporting period.
    - The total eligible member patient encounter volume over the previously determined continuous 90-day reporting period.
    - The total patient encounter volume over the previously determined continuous 90-day reporting period.

Topic #12077

Reviewing, Confirming, and Submitting the EHR Incentive Program Application

After completing attestations for the EHR (Electronic Health Record) Incentive Program, the Eligible Professional will be asked to review all answers provided. An error-checking function will identify any errors found in the application.

Final submission will require an electronic signature by providing the preparer or the Eligible Professional's initials, the Eligible Professional's NPI (National Provider Identifier) and the Eligible Professional's personal TIN (tax identification number). If

completed through the use of an authorized preparer, that preparer will also need to include his or her name and relationship to the Eligible Professional and then electronically sign the application before submission. Once the Wisconsin Medicaid EHR Incentive Program application has been completed and submitted, an e-mail notification will be sent to confirm the application's submission. After an application is successfully submitted and approved, Eligible Professionals can expect payments within 45 days.

Resources for EHR Incentive Program

Topic #12138

Provider Services

Eligible Professionals and Eligible Hospitals should call Provider Services with all questions regarding the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program.

Topic #12139

User Guide

Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program User Guides for Eligible Professionals and Eligible Hospitals are available on the Portal User Guides page of the Provider area of the ForwardHealth Portal.

Topic #12140

Web Sites

The following Web sites provide additional information regarding the EHR (Electronic Health Record) Incentive Program.

Available Resources	Web Sites
Wisconsin Medicaid EHR Incentive Program Web Site	www.dhs.wisconsin.gov/ehrincentive/
CMS (Centers for Medicare and Medicaid Services) EHR Incentive Program	https://www.cms.gov/EHRIncentivePrograms/
Wisconsin Health Information Technology Extension Center Web Site	www.whitec.org/

Provider Enrollment and Ongoing Responsibilities

4

Archive Date:06/03/2013

Provider Enrollment and Ongoing Responsibilities:Documentation

Topic #6277

1099 Miscellaneous Forms

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

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

Topic #1918

Accounting Method

RHCs (rural health clinics) are required to:

- Maintain cost data on the accrual basis of accounting (i.e., revenue and expenses are identified with specific periods of time to which they apply regardless of when revenue is received or an expense is paid).
- Use generally accepted accounting principles.

Topic #1917

Audits

An RHC (rural health clinic) shall permit access to medical or financial records by Wisconsin Medicaid for the purposes of inspection, review, audit, or reproduction in accordance with DHS 106.02(9)(e)4, Wis. Admin. Code.

Medicare Audits

The Medicare intermediary may perform audits of the RHC. Medicare audit results may affect the results of the RHC's Medicaid annual settlement. Wisconsin Medicaid may reopen the settlement and determine an additional cash payout to the RHC or recoupment to Wisconsin Medicaid.

Topic #1640

Availability of Records to Authorized Personnel

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

records are released to an authorized DHCAA staff member(s).

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

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

Also, state-contracted MCOs (managed care organizations), including HMOs (health maintenance organizations) and SSI (Supplemental Security Income) HMOs, are not reimbursed for the reproduction costs covered in their contract with the DHS (Department of Health Services).

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

Topic #200

Confidentiality and Proper Disposal of Records

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

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

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

HIPAA Privacy and Security Regulations

Definition of Protected Health Information

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

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

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

Requirements Regarding "Unsecured" Protected Health Information

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

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

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

Actions Required for Proper Disposal of Records

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

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

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

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

Wisconsin Confidentiality Laws

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

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

"Personally Identifiable Data" Protected

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

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

Actions Required for Proper Disposal of Records

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

Businesses Affected

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

Continuing Responsibilities for All Providers After Ending Participation

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

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

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

Penalties for Violations

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

- Fines up to $1.5 million per calendar year.
- Jail time.
- Federal HHS Office of Civil Rights enforcement actions.

For entities not subject to HIPAA, s.134.97(4), Wis. Stats., imposes penalties for violations of confidentiality laws. Any provider or provider's business partner who violates Wisconsin confidentiality laws may be subject to fines up to $1,000 per incident or occurrence.

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

Topic #1916

Financial Record Keeping

RHCs (rural health clinics) are required to maintain medical and financial records and documentation in accordance with DHS 106.02(9), Wis. Admin. Code. These regulations require the RHC to:

- Maintain adequate cost data based on financial and statistical records that can be verified by qualified auditors.
- Develop cost information that is current, accurate, and in sufficient detail to support payments made for services rendered to members. This includes all ledgers, records, and original evidences of cost (e.g., purchase requisitions, purchase orders, vouchers, payroll vouchers), which pertain to the determination of reasonable cost.
- Maintain financial and statistical records in a consistent manner from one period to another.

Topic #201

Financial Records

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

Topic #202

Medical Records

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

Topic #199

Member Access to Records

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

Fees for Health Care Records

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

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

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

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

For information regarding fees that may be charged to members for copies of health care records, refer to s. 146.83(3f), Wis. Stats.

Topic #203

Preparation and Maintenance of Records

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

Topic #1915

Record Retention

All providers (including RHCs (rural health clinics) and BadgerCare Plus HMOs) are required to maintain records that fully document the basis of charges upon which all claims for reimbursement are made, in accordance with DHS 106.02(9), Wis. Admin. Code. RHCs are required to retain records for a minimum of six years from the date of reimbursement.

Note: Most providers are required to retain records for a minimum of five years from the date of reimbursement.

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

Reviews and Audits

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

Topic #205

Records Requests

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

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

Request from a Member or Authorized Person

If the request for a member's billing information or medical claim records is from a member or authorized person acting on behalf of the member, the provider should send a copy of the requested billing information or medical claim records, along with the name and address of the requester, to the following address:

Department of Health Services
Casualty/Subrogation Program
PO Box 6243
Madison WI 53791

ForwardHealth will process and forward the requested information to the requester.

Request from an Attorney, Insurance Company, or Power of Attorney

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

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

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

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

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

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

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

Request for a Statement from a Dual Eligible

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

Topic #1646

Release of Billing Information to Government Agencies

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

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

Topic #1914

Settlement Reclassifications

RHCs (rural health clinics) that maintain their records on a cash basis of accounting need to adjust items from the cash basis to accrual basis for the cost report. (RHCs using the cash basis of accounting record revenues and expenses when they are received and when they are paid, without regard to the period to which they apply.) These adjustments do not need to be recorded in the

formal accounting records, but may be made in supplementary records. Adjustments are necessary, for example, if the RHC:

- Pays expenses applicable to future periods.
- Incurs expenses in one reporting period that are not paid until the next period.
- Purchases supplies to be used in subsequent periods.
- Records expenses for capital asset expenditures rather than the allowable depreciation on such assets.

Ongoing Responsibilities

Topic #220

Accommodating Members with Disabilities

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

Topic #215

Change in Ownership

New provider enrollment materials, including a provider agreement, must be completed whenever a change in ownership occurs. ForwardHealth defines a "change in ownership" as when a different party purchases (buys out) or otherwise obtains ownership or effective control over a practice or facility. Examples of a change in ownership include the following:

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

The following provider types require Medicare enrollment and/or DQA (Division of Quality Assurance) certification for Wisconsin Medicaid enrollment change in ownerships:

- Ambulatory surgery centers.
- ESRD (end-stage renal disease) services providers.
- FQHCs (federally qualified health centers).
- Home health agencies.
- Hospice providers.
- Hospitals (inpatient and outpatient).
- Nursing homes.
- Outpatient rehabilitation facilities.
- Rehabilitation agencies.
- RHCs (rural health clinics).

All changes in ownership must be reported in writing to ForwardHealth and new provider enrollment materials must be completed *before* the effective date of the change. The affected provider numbers should be noted in the letter. When the change in ownership is complete, the provider(s) will receive written notification of his or her provider number and the new Medicaid enrollment effective date in the mail.

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

Repayment Following Change in Ownership

Medicaid-enrolled providers who sell or otherwise transfer their business or business assets are required to repay ForwardHealth for any erroneous payments or overpayments made to them by Wisconsin Medicaid. If necessary, the provider to whom a

transfer of ownership is made will also be held liable by ForwardHealth for repayment. Therefore, prior to final transfer of ownership, the provider acquiring the business is responsible for contacting ForwardHealth to ascertain if he or she is liable under this provision.

The provider acquiring the business is responsible for making payments within 30 days after receiving notice from the DHS (Department of Health Services) that the amount shall be repaid in full.

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

Division of Health Care Access and Accountability
Bureau of Program Integrity
PO Box 309
Madison WI 53701-0309

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

Topic #219

Civil Rights Compliance (Nondiscrimination)

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

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

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

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

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

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

Providers are required to be in compliance with the previously mentioned laws as they are currently in effect or amended. Providers who employ 25 or more employees and receive $25,000 or more annually in Medicaid reimbursement are also

required to comply with the DHS (Department of Health Services) Affirmative Action and Civil Rights Compliance Plan requirements. Providers that employ less than 25 employees and receive less than $25,000 annually in Medicaid reimbursement are required to comply by submitting a Letter of Assurance and other appropriate forms.

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

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

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

Title VI of the Civil Rights Act of 1964

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

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

Title VII of the Civil Rights Act of 1964

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

Federal Rehabilitation Act of 1973, Section 504

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

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

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

In addition, Section 504 requires "program accessibility," which may mean building accessibility, outreach, or other measures that

allow for full participation of the handicapped individual. In determining program accessibility, the program or activity will be viewed in its entirety. In choosing a method of meeting accessibility requirements, the provider shall give priority to those methods that offer a person who is disabled services that are provided in the most integrated setting appropriate.

Americans with Disabilities Act of 1990

Under Title III of the ADA (Americans with Disabilities Act) of 1990, any provider that operates an existing public accommodation has four specific requirements:

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

Age Discrimination Act of 1975

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

Topic #198

Contracted Staff

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

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

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

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

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

Topic #216

Examples of Ongoing Responsibilities

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

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

Topic #217

Keeping Information Current

Types of Changes

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

- Address(es) — practice location and related information, mailing, PA (prior authorization), and/or financial.
- Business name.
- Contact name.
- Federal Tax ID number (IRS (Internal Revenue Service) number).
- Group affiliation.
- Licensure.
- NPI (National Provider Identifier).
- 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 in the event that provider mail is returned to ForwardHealth for lack of a current address.

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

Address Changes

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

Submitting Changes in Address or Status

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

ForwardHealth Portal Submission

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

Providers should note, however, that the demographic update function of the Portal limits certain providers from modifying some types of information. Providers who are not able to modify certain information through the Portal may make these changes using the Provider Change of Address or Status (F-01181 (07/12)) form.

Paper Submission

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

Change Notification Letter

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

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

Notify Division of Quality Assurance of Changes

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

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

Topic #577

Legal Framework

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

- Federal Law and Regulation:
  - Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
  - Regulation — Title 42 CFR Parts 430-498 and Parts 1000-1008 (Public Health).
- Wisconsin Law and Regulation:
  - Law — Wisconsin Statutes: 49.43-49.499, 49.665, and 49.473.
  - Regulation — Wisconsin Administrative Code, Chapters DHS 101, 102, 103, 104, 105, 106, 107, and 108.

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

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

Topic #1968

The RHC (rural health clinic) benefit is based on the RHC Services Act of 1977, Federal Public Law 95-210.

Topic #15157

Recovery Audit Contractor Audits

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

Note: The RAC will not audit claims submitted for Family Planning Only Services, SeniorCare, WCDP (Wisconsin Chronic Disease Program), the WWWP (Wisconsin Well Woman Program), and ADAP (Wisconsin AIDS/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 (800) 310-0865. Refer to the RAC Web site for additional information regarding HMS RAC activities.

Topic #13277

Reporting Suspected Waste, Fraud, and Abuse

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

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

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

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

Reporting Suspected Fraud and Abuse

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

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

- Going to the OIG fraud and abuse reporting Web site.
- Calling the DHS fraud and abuse hotline at (877) 865-3432.

The following information is helpful when reporting fraud and abuse:

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

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

Prescription

Topic #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).
- Brand medically necessary drugs that require PA.
- Diagnosis-restricted drugs.
- Age-restricted and gender-restricted drugs.

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

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

for more information.

Preferred Drug List

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

Prescriber Responsibilities for Non-preferred Drugs

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

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

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

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

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

Diagnosis-Restricted Drugs

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

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

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

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

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

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

Members Enrolled in the BadgerCare Plus Standard Plan, Medicaid, or SeniorCare (Levels 1 and 2a)

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

To submit a PA request for a drug without a signed rebate agreement, the prescriber should complete and submit the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/12)) to the pharmacy where the drug will be dispensed. Pharmacies should complete the PA/RF (Prior Authorization Request Form, F-11018 (07/12)) and submit both forms and any supporting documentation to ForwardHealth. PAs can be submitted by paper, fax, or on the ForwardHealth Portal.

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

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

If a PA request for a drug without a signed manufacturer rebate is approved, claims for drugs without a signed rebate agreement must be submitted on paper. Providers should complete and submit the Noncompound Drug Claim (F-13072 (07/12)) indicating the actual NDC of the drug with the Pharmacy Special Handling Request (F-13074 (07/12)) form.

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

Members Enrolled in SeniorCare (Levels 2b and 3)

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

Members Enrolled in the BadgerCare Plus Benchmark, the BadgerCare Plus Core Plan, and the BadgerCare Plus Basic Plan

PA is not available for drugs that are not included on the BadgerCare Plus Benchmark Plan Product List, BadgerCare Plus Core Plan Product List, BadgerCare Plus Core Plan Brand Name Drugs Quick Reference, and the BadgerCare Plus Basic Plan Product List. PA requests submitted for noncovered drugs will be returned to providers unprocessed and the services will not be covered. Members do not have appeal rights regarding returned PA requests for noncovered drugs.

Drug Utilization Review System

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

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

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

Prospective Drug Utilization Review's Impact on Prescribers

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

Drugs with Three-Month Supply Requirement

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

Member Benefits

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

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

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

Prescription Quantity

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

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

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

Prescription Mail Delivery

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

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

Noncovered Drugs

The following drugs are not covered:

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

SeniorCare

SeniorCare is a prescription drug assistance program for Wisconsin residents who are 65 years of age or older and meet eligibility criteria. SeniorCare is modeled after Wisconsin Medicaid in terms of drug coverage and reimbursement, although there are a few differences. Unlike Medicaid, SeniorCare does not cover OTC drugs other than insulin.

Topic #4346

Tamper-Resistant Prescription Pad Requirement

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

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

Required Features for Tamper-Resistant Prescription Pads or Computer Paper

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

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

Exclusions to Tamper-Resistant Prescription Pad Requirement

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

- Prescriptions faxed directly from the prescriber to the pharmacy.
- Prescriptions electronically transmitted directly from the prescriber to the pharmacy.
- Prescriptions telephoned directly from the prescriber to the pharmacy.

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

72-Hour Grace Period

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

Coordination of Benefits

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

Retroactive Medicaid Eligibility

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

Penalty for Noncompliance

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

Provider Enrollment

Topic #899

CLIA Certification or Waiver

Congress implemented CLIA (Clinical Laboratory Improvement Amendment) to improve the quality and safety of laboratory services. CLIA requires *all* laboratories and providers that perform tests (including waived tests) for health assessment or for the diagnosis, prevention, or treatment of disease or health impairment to comply with specific federal quality standards. This requirement applies even if only a single test is being performed.

CLIA Enrollment

The federal CMS (Centers for Medicare and Medicaid Services) sends CLIA enrollment information to ForwardHealth. The enrollment information includes CLIA identification numbers for all current laboratory sites. ForwardHealth verifies that laboratories are CLIA certified before Medicaid grants enrollment.

CLIA Regulations

ForwardHealth complies with the following federal regulations as initially published and subsequently updated:

- Public Health Service Clinical Laboratory Improvement Amendments of 1988.
- Title 42 CFR Part 493, Laboratory Requirements.

Scope of CLIA

CLIA governs all laboratory operations including the following:

- Accreditation.
- Certification.
- Fees.
- Patient test management.
- Personnel qualifications.
- Proficiency testing.
- Quality assurance.
- Quality control.
- Records and information systems.
- Sanctions.
- Test methods, equipment, instrumentation, reagents, materials, supplies.
- Tests performed.

CLIA regulations apply to *all* providers who perform CLIA-monitored laboratory services, including, but not limited to, the following:

- Clinics.
- HealthCheck providers.
- Independent clinical laboratories.
- Nurse midwives.

- Nurse practitioners.
- Osteopaths.
- Physician assistants.
- Physicians.
- Rural health clinics.

CLIA Certification Types

The CMS regulations require providers to have a CLIA certificate that indicates the laboratory is qualified to perform a category of tests.

Clinics or groups with a single group billing certification, but multiple CLIA numbers for different laboratories, may wish to contact Provider Services to discuss various certification options. There are five types of CLIA certificates as defined by CMS:

1. *Certificate of Waiver*. This certificate is issued to a laboratory to perform only waived tests. The CMS Web site identifies the most current list of waived procedures. BadgerCare Plus identifies allowable waived procedures in maximum allowable fee schedules.
2. *Certificate for Provider-Performed Microscopy Procedures (PPMP)*. This certificate is issued to a laboratory in which a physician, mid-level practitioner, or dentist performs no tests other than the microscopy procedures. This certificate permits the laboratory to also perform waived tests. The CMS Web site identifies the most current list of CLIA-allowable provider-performed microscopy procedures. BadgerCare Plus identifies allowable provider-performed microscopy procedures in fee schedules.
3. *Certificate of Registration*. This certificate is issued to a laboratory and enables the entity to conduct moderate- or high-complexity laboratory testing, or both, until the entity is determined by survey to be in compliance with CLIA regulations.
4. *Certificate of Compliance*. This certificate is issued to a laboratory after an inspection that finds the laboratory to be in compliance with all applicable CLIA requirements.
5. *Certificate of Accreditation*. This is a certificate that is issued to a laboratory on the basis of the laboratory's accreditation by an accreditation organization approved by CMS. The six major approved accreditation organizations are:
    - The Joint Commission.
    - CAP (College of American Pathologists).
    - COLA.
    - American Osteopathic Association.
    - American Association of Blood Banks.
    - ASHI (American Society of Histocompatibility and Immunogenetics).

Applying for CLIA Certification

Use the CMS 116 CLIA application to apply for program certificates. Providers may obtain CMS 116 forms from the CMS Web site or from the following address:

Division of Quality Assurance
Clinical Laboratory Section
1 W Wilson St
PO Box 2969
Madison WI 53701-2969

Providers Required to Report Changes

Providers are required to notify Provider Maintenance in writing within 30 days of any change(s) in ownership, name, location, or director. Also, providers are required to notify Provider Maintenance of changes in CLIA certificate types immediately and within six months when a specialty/subspecialty is added or deleted. Following is the address for providing written notification to Provider Maintenance:

ForwardHealth
Provider Maintenance
313 Blettner Blvd
Madison WI 53784

If a provider has a new certificate type to add to its certification information on file with ForwardHealth, the provider should send a copy of the new certificate to the above address. When a provider sends ForwardHealth a copy of a new CLIA certificate, the effective date on the certificate will become the effective date for CLIA certification on file with ForwardHealth.

Topic #3969

Categories of Enrollment

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

- Billing/rendering provider.
- Rendering-only provider.
- Billing-only provider (including group billing).

Providers should refer to the service-specific information in the Online Handbook or the Information for Specific Provider Types page on the Provider Enrollment Information home page to identify which category of enrollment is applicable.

Billing/Rendering Provider

Enrollment as a billing/rendering provider allows providers to identify themselves on claims (and other forms) as either the provider billing for the services or the provider rendering the services.

Rendering-Only Provider

Enrollment as a rendering-only provider is given to those providers who practice under the professional supervision of another provider (e.g., physician assistants). Providers with a rendering provider enrollment cannot submit claims to Wisconsin Medicaid directly, but they have reimbursement rates established for their provider type. Claims for services provided by a rendering provider must include the supervising provider or group provider as the billing provider.

Billing-Only Provider (Including Group Billing)

Enrollment as a billing-only provider is given to certain provider types when a separate rendering provider is required on claims.

Group Billing

Groups of individual practitioners are enrolled as billing-only providers as an accounting convenience. This allows the group to receive one reimbursement, one RA (Remittance Advice), and the 835 (835 Health Care Claim Payment/Advice) transaction for covered services rendered by individual practitioners within the group.

Providers may not have more than one group practice enrolled in Wisconsin Medicaid with the same ZIP+4 code address, NPI (National Provider Identifier), and taxonomy code combination. Provider group practices located at the same ZIP+4 code address are required to differentiate their enrollment using an NPI or taxonomy code that uniquely identifies each group practice.

Individual practitioners within group practices are required to be Medicaid-enrolled because these groups are required to identify

the provider who rendered the service on claims. Claims indicating these group billing providers that are submitted without a rendering provider are denied.

Topic #1923

Definitions

According to Wisconsin Medicaid and BadgerCare Plus, an RHC (rural health clinic):

- Is an outpatient health clinic located in a rural area designated by the U.S. HHS (Department of Health and Human Services) as a rural shortage area.
- Is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.
- Complies with all other appropriate federal, state, and local laws.
- Meets all other requirements of RHC certification.

A *rural area* is an area that is not delineated as an urbanized area by the U.S. Bureau of Census.

A *rural shortage area* is a defined geographic area designated by the federal HHS under the Public Health Services Act as having either a shortage of personal health services or a shortage of primary medical care providers.

Types of Rural Health Clinics

RHCs can be privately or publicly owned. The two types of RHCs, as designated by Medicare RHC regulations, are:

- Independent RHCs: These RHCs are freestanding and are not part of a hospital, SNF (skilled nursing facility), or home health agency.
- Provider-Based RHCs: These RHCs are part of a hospital, skilled nursing facility, or home health agency, and may be either located with the parent organization or satellite clinic.

Clinics are subject to different cost-based reimbursement methods depending on their type. Wisconsin Medicaid and BadgerCare Plus recognize the Medicare classification of RHCs.

Topic #14137

Enrollment Requirements Due to the Affordable Care Act

In 2010, the federal government signed into law the ACA (Affordable Care Act), also known as federal health care reform, which affects several aspects of Wisconsin health care. ForwardHealth has been working toward ACA compliance by implementing some new requirements for providers and provider screening processes. To meet federally mandated requirements, ForwardHealth is implementing changes in phases, the first of which began in 2012. A high-level list of the changes included under ACA is as follows:

- Providers are assigned a risk level of limited, moderate, or high. Most of the risk levels have been established by the CMS (Centers for Medicare and Medicaid Services) based on an assessment of potential fraud, waste, and abuse for each provider type.
- Providers are screened according to their assigned risk level. Screenings are conducted during initial enrollment and revalidation.
- Certain provider types are subject to an enrollment application fee of $523. This fee has been federally mandated and may be adjusted annually. The fee is used to offset the cost of conducting screening activities.

- During the enrollment process, providers are required to provide additional information for persons with an ownership or controlling interest, managing employees, and agents. "Persons" in this instance may mean a person or a corporation.
- Providers are required to undergo revalidation every three to five years.
- Effective July 15, 2013, ordering and referring physicians or other professionals will be required to be enrolled as a participating Medicaid provider.
- Payment suspensions are imposed on providers based on a credible allegation of fraud.

ForwardHealth Implementation of Affordable Care Act Requirements to Date

Provider Screenings

Wisconsin Medicaid screens all enrolling providers to accommodate the ACA limited risk level screening requirements. Limited risk level screening activities include:

- Checking federal databases, which include:
  - The SSA (Social Security Administration's) Death Master File.
  - The NPPES (National Plan and Provider Enumeration System).
  - OIG (Office of the Inspector General) LEIE (List of Excluded Individuals/Entities).
  - EPLS (The Excluded Parties List System).
  - MED (Medicare Exclusion Database).
- Verifying licenses are appropriate in accordance with state laws and that there are no current limitations on the license.

These screening activities are conducted on applicants, providers, and any person with an ownership or controlling interest or who is an agent or managing employee of the provider at the time of enrollment, on a monthly basis for enrolled providers, and at revalidation.

ForwardHealth will deny enrollment or terminate the enrollment of any provider where any person with a five percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years, or if invalid licensure information is found.

Additional Information Needed During Provider Enrollment

ForwardHealth collects some personal data information from persons with an ownership or controlling interest, agents, and managing employees. ForwardHealth will only use the provided information for provider enrollment. All information provided will be protected under the HIPAA (Health Insurance Portability and Accountability Act of 1996) privacy rule.

Providers are required to submit the following information at the time of enrollment and revalidation for their individual owners with a controlling interest:

- First and last name.
- Provider's SSNs (Social Security numbers).
- Dates of birth.
- Street address, city, state, and ZIP+4 code.

Providers are required to submit the following information at the time of enrollment and revalidation for their organizational owners with controlling interest:

- Legal business name.
- Tax identification number.
- Business street address, city, state, ZIP+4 code.

Providers are required to submit the following information at the time of enrollment and revalidation for their managing employees and agents:

- First and last name.
- Employees' and agents' SSNs.
- Dates of birth.
- Street address, city, state, and ZIP+4 code.

Topic #1922

Individual Provider Enrollment

For the purpose of Wisconsin Medicaid, RHCs (rural health clinics) are enrolled as billing providers for fee-for-service reimbursement. Each RHC rendering provider must be individually enrolled.

The types of reimbursable RHC services that require individual rendering provider enrollment are:

- Physician services.
- Physician assistant services.
- Nurse practitioner services.
- Nurse midwife services.
- Outpatient mental health and outpatient substance abuse services.
- Other services, as necessary.

Topic #193

Materials for New Providers

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

Topic #194

Non-enrolled In-State Emergency Providers

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

Claims from non-enrolled in-state providers must be submitted with an In-State Emergency Provider Data Sheet (F-11002 (07/12)). The In-State Emergency Provider Data Sheet provides ForwardHealth with minimal tax and licensure information.

Non-enrolled in-state providers may call Provider Services with questions.

Topic #1921

Nurse Practitioners and Nurse Midwives

Nurse practitioners and nurse midwives who treat members are required to be enrolled in Wisconsin Medicaid. This applies to nurse practitioners whose services are reimbursed under a physician's or clinic's billing provider NPI (National Provider Identifier), as well as those who independently submit claims to ForwardHealth. This does not apply to ancillary providers who practice under the direct on-site supervision of a physician.

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 through the ForwardHealth Portal or by using the Provider Change of Address or Status (F-01181 (07/12)) form.

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

Topic #14157

Provider Enrollment Information Home Page

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

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

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

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

- General enrollment information.

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

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

Topic #1931

Provider Type and Specialty Changes

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

Topic #14317

Terminology to Know for Provider Enrollment

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

New Terminology	Definition
Agent	Any person who has been delegated the authority to obligate or act on behalf of a provider.
Disclosing entity	A Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.
Federal health care programs	Federal health care programs include Medicare, Medicaid, Title XX, and Title XXI.
Other disclosing agent	Any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVII, or XX of the Act. This includes: • Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or HMO that participates in Medicare (Title XVIII). • Any Medicare intermediary or carrier. • Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or XX of the Act.
Indirect ownership	An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership in the disclosing entity.
Managing employee	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.
Ownership interest	The possession of equity in the capital, the stock, or the profits of the disclosing entity.
Person with an ownership or control interest	A person or corporation for which one or more of the following applies: • Has an ownership interest totaling five percent or more in a disclosing entity. • Has an indirect ownership interest equal to five percent or more in a disclosing entity. • Has a combination of direct and indirect ownership interest equal to five percent or more in a

	disclosing entity. • Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or asset of the disclosing entity. • Is an officer or director of a disclosing entity that is organized as a corporation. • Is a person in a disclosing entity that is organized as a partnership.
Subcontractor	• An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or, • An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.
Re-enrollment	Re-enrollment of a provider whose Medicaid enrollment has ended for any reason other than sanctions or failure to revalidate may be re-enrolled as long as all licensure and enrollment requirements are met. If a provider's enrollment with Wisconsin Medicaid lapses for longer than one year, they will have to re-enroll as a "new" provider. Providers should note that when they re-enroll, application fees and screening activities may apply. Re-enrollment was formerly known as re-instate.
Revalidation	All enrolled providers are required to revalidate their enrollment information every three years to continue their participation with Wisconsin Medicaid. Revalidation was formerly known as recertification.

Note: Providers should note that the CMS (Centers for Medicare and Medicaid Services) requires revalidation at least every five years. However, Wisconsin Medicaid will continue to revalidate providers every three years.

Provider Numbers

Topic #1913

Billing Rendering Provider

Physicians, nurse practitioners, nurse midwives, psychiatrists, and psychologists are issued an NPI (National Provider Identifier) that allows them to identify themselves on the 1500 Health Insurance Claim Form as either the biller or the performer of services when a clinic or group is submitting claims for the services.

Topic #1912

Group Billing National Provider Identifiers

RHCs (rural health clinics) are issued a group billing NPI (National Provider Identifier) and receive one reimbursement and one RA (Remittance Advice) for RHC services performed by individual providers within the RHC.

Claims submitted by the RHC under the group billing NPI must identify a Medicaid-enrolled *rendering* provider on the claim form. A claim submitted with only an RHC group billing NPI is denied reimbursement. An RHC may submit claims for most services (including physician, physician assistant, nurse practitioner, and nurse midwife services) using its group billing provider NPI and an appropriate rendering provider NPI. Claims for services that are not RHC services may be submitted under the individual rendering provider's NPI or under a separate physician/clinic group billing NPI issued to the facility.

Wisconsin Medicaid does not reimburse RHCs for providing outpatient mental health/substance abuse services performed by a Master's level therapist when using the RHC group billing NPI. Clinics must use the appropriate billing number(s) for these services (i.e., outpatient mental health/substance abuse clinic group billing NPI).

Claims for outpatient mental health/substance abuse services performed by a Master's-level provider must be submitted using the outpatient mental health/substance abuse clinic group billing NPI. Claims for home health services must be submitted using a home health agency group billing NPI.

Topic #3421

Provider Identification

Health Care Providers

Health care providers are required to indicate an NPI (National Provider Identifier) on enrollment applications and electronic and paper transactions submitted to ForwardHealth.

The NPI is a 10-digit number obtained through the NPPES (National Plan and Provider Enumeration System).

Providers should ensure that they have obtained an appropriate NPI prior to beginning their enrollment application. There are two kinds of NPIs:

- Entity Type 1 NPIs are for individuals who provide health care, such as physicians, dentists, and chiropractors.
- Entity Type 2 NPIs are for organizations that provide health care, such as hospitals, group practices, pharmacies, and home

health agencies.

It is possible for a provider to qualify for both Entity Type 1 and Entity Type 2 NPIs. For example, an individual physical therapist may also be the owner of a therapy group that is a corporation and have two Wisconsin Medicaid enrollments — one enrollment as an individual physical therapist and the other enrollment as the physical therapy group. A Type 1 NPI for the individual enrollment and a Type 2 NPI for the group enrollment are required.

NPIs and classifications may be viewed on the NPPES Web site. The CMS (Centers for Medicare and Medicaid Services) Web site includes more information on Type 1 and Type 2 NPIs.

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

Non-healthcare Providers

Non-healthcare providers, such as SMV (specialized medical vehicle) providers, personal care agencies, and blood banks, are exempt from federal NPI requirements. Providers exempt from federal NPI requirements are assigned a Medicaid provider number once their enrollment application is accepted; they are required to indicate this Medicaid provider number on electronic and paper transactions submitted to ForwardHealth.

Topic #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 found in the secure Provider area of the ForwardHealth Portal. Refer to the Demographic Maintenance Tool User Guide on the Portal User Guides page of the Portal for more detailed instructions. 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.

Alternatively, providers may use the Provider Change of Address or Status (F-01181 (07/12)) form to report new taxonomy codes. Providers who submit new taxonomy codes using the Provider Change of Address or Status form will need to check the demographic maintenance tool to verify ForwardHealth has received and added the new taxonomy codes prior to using them on transactions.

Omission of a taxonomy code when it is required as additional data to identify the provider will cause claims and other transactions to be denied or delayed in processing.

Note: Taxonomy codes do not change provider enrollment or affect reimbursement terms.

Topic #5097

ZIP Code

The ZIP code of a provider's practice location address on file with ForwardHealth must be a ZIP+4 code. The ZIP+4 code helps to identify a provider when the NPI (National Provider Identifier) reported to ForwardHealth corresponds to multiple enrollments and the reported taxonomy code does not uniquely identify the provider.

When a ZIP+4 code is required to identify a provider, omission of it will cause claims and other transactions to be denied or delayed in processing.

Providers may verify the ZIP+4 code for their address on the U.S. Postal Service Web site.

Provider Rights

Topic #208

A Comprehensive Overview of Provider Rights

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

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

Topic #207

Ending Participation

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

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

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

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

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

ForwardHealth
Provider Maintenance
313 Blettner Blvd
Madison WI 53784

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

Topic #209

Hearing Requests

A provider who wishes to contest a DHS (Department of Health Services) action or inaction for which due process is required

under s. 227, Wis. Stats., may request a hearing by writing to the DHA (Division of Hearings and Appeals).

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

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

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

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

Topic #1217

Annual Settlement Adjustments

An RHC (rural health clinic) has 60 days to request an adjustment after receiving notification of its settlement or recoupment amount from Medicaid. The adjustment request may include additional expenses and/or allowable encounters. To be included in an adjustment, an encounter must have been submitted to and paid by Wisconsin Medicaid within 365 days of the DOS (date of service), as required by state law, and the DOS (not the paid date) of the encounter must fall within the clinic's fiscal year for which the settlement report was submitted.

If the RHC does not ask for an adjustment within 60 days of notification of the original settlement payment or recoupment, Wisconsin Medicaid considers the settlement final. An RHC should verify that all expenses and encounters have been included in the settlement before the 60-day deadline. Wisconsin Medicaid may adjust the settlement based on Medicare's final audit of an RHC.

RHCs are responsible for verifying that all expenses and encounters are included in the cost report. A settlement cannot be reopened once it has been finalized (i.e., after the 60-day adjustment request period), except in cases where an audit requires Wisconsin Medicaid to revise the settlement.

Topic #210

Limiting the Number of Members

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

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

Topic #206

Requesting Discretionary Waivers and Variances

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

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

Requirements

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

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

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

Application

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

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

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

Division of Health Care Access and Accountability
Waivers and Variances
PO Box 309
Madison WI 53701-0309

Revalidation

Topic #8517

An Overview

Each year approximately one-third of all Medicaid-enrolled providers undergo a revalidation process, during which they update their enrollment information and sign the Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation. Providers are required to complete the revalidation process to continue their participation with Wisconsin Medicaid. Wisconsin Medicaid will notify providers when they need to revalidate their enrollment information and provide instructions on how to complete the revalidation process. Most providers will conduct their revalidation process on the ForwardHealth Portal.

Topic #8521

Checking the Status of a Revalidation Application

Providers may check the status of their revalidation on the ForwardHealth Portal by entering the ATN (application tracking number) from the Provider Revalidation Notice and pressing "Search."

Providers will receive one of the following status responses:

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

Note: Status responses may not yet reflect changes in certification terminology which are being made in compliance with the ACA (Affordable Care Act).

Topic #8519

Notification Letters

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

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

The letters are sent to the mailing address on file with Wisconsin Medicaid. Providers should read these letters carefully and keep them for reference. The letters contain information necessary to log in to the secure Revalidation area of the Portal to complete the revalidation process. If a provider needs to replace one of the letters, the revalidation process will be delayed.

Topic #8522

Revalidation Completed by an Authorized Representative

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

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

Sanctions

Topic #211

Intermediate Sanctions

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

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

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

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

Topic #212

Involuntary Termination

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

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

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

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

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

Topic #213

Sanctions for Collecting Payment from Members

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

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

Topic #214

Withholding Payments

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

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

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

Reimbursement

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Archive Date:06/03/2013

Reimbursement:Amounts

Topic #8117

Electronic Funds Transfer

EFT (electronic funds transfer) allows ForwardHealth to directly deposit payments into a provider's designated bank account for a more efficient delivery of payments than the current process of mailing paper checks. EFT is secure, eliminates paper, and reduces the uncertainty of possible delays in mail delivery.

Only in-state and border-status providers who submit claims and MCOs (managed care organizations) are eligible to receive EFT payments.

Provider Exceptions

EFT payments are not available to the following providers:

- In-state emergency providers.
- Out-of-state providers.
- Out-of-country providers.
- SMV (specialized medical vehicle) providers during their provisional enrollment period.

Enrolling in Electronic Funds Transfer

A ForwardHealth Portal account is required to enroll into EFT as all enrollments must be completed via a secure Provider Portal account or a secure MCO Portal account. Paper enrollments are not accepted. A separate EFT enrollment is required for each financial payer a provider bills.

Providers who do not have a Portal account may Request Portal Access online. Providers may also call the Portal Helpdesk for assistance in requesting a Portal account.

The following guidelines apply to EFT enrollment:

- Only a Portal Administrator or a clerk that has been assigned the "EFT" role on the Portal may complete the EFT enrollment information.
- Organizations cannot revert back to receiving paper checks once enrolled in EFT.
- Organizations may change their EFT information at any time.
- Organizations will continue to receive their Remittance Advice as they do currently.

Refer to the Electronic Funds Transfer User Guide on the Portal User Guides page of the Portal for instructions and more information about EFT enrollment.

Providers will continue to receive payment via paper check until the enrollment process moves into "Active" status and the provider's ForwardHealth EFT enrollment is considered complete.

Recoupment and Reversals

Enrollment in EFT does not change the current process of recouping funds. Overpayments and recoupment of funds will continue

to be conducted through the reduction of payments.

Note: Enrolling in EFT does not authorize ForwardHealth to make unauthorized debits to the provider's EFT account; however, in some instances an EFT reversal of payment may be necessary. For example, if the system generates a payment twice or the amount entered manually consists of an incorrect value (e.g., a decimal point is omitted creating a $50,000 keyed value for a $500 claim), a reversal will take place to correct the error and resend the correct transaction value. ForwardHealth will notify the designated EFT contact person of an EFT reversal if a payment is made in error due to a system processing or manual data entry error.

Problem Resolution

If payment is not deposited into the designated EFT account according to the ForwardHealth payment cycle, providers should first check with their financial institution to confirm the payment was received. If the payment was not received, providers should then call Provider Services to resolve the issue and payment by paper check will be reinstated until the matter has been resolved.

Topic #1894

Managed Care Supplemental Payments

RHCs (rural health clinics) that provide services under a contract with a BadgerCare Plus HMO (health maintenance organization) receive state supplemental payment for the cost of providing these services. These supplemental payments are an estimate of the difference between the payment the RHC receives from the HMO(s) and the payments the RHC would have received under the alternative cost settlement method.

At the end of each RHC fiscal year, the total amount of supplemental and HMO payments received by an RHC is reviewed against the payment amount that the number of visits provided under the RHC's contract with the HMO would have yielded under the alternative method. The RHC is paid the difference between the amount calculated using the alternative cost settlement method and the actual number of visits and the total amount of supplemental and HMO payments received by the RHC, if the alternative amount exceeds the total amount of supplemental and HMO payments.

If the alternative amount is less than the total amount of supplemental and HMO payments, Wisconsin Medicaid will recoup the difference.

Topic #4385

Pharmacy Services and Some Drug-Related Supplies

Pharmacy services and some drug-related supplies for managed care members are reimbursed by fee-for-service.

The following provider-administered drugs and related administration codes are reimbursed by fee-for-service, not a member's MCO (managed care organization), for members enrolled in BadgerCare Plus HMOs, Medicaid SSI (Supplemental Security Income) HMOs, and most special managed care programs if the service is covered by BadgerCare Plus and Medicaid:

- All "J" codes.
- Drug-related "Q" codes.
- A limited number of related administration codes.

For members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, claims for these services should be submitted to BadgerCare Plus and Medicaid fee-for-service.

MCOs are responsible for reimbursing providers for all other provider-administered drugs, such as drug claims submitted with a

CPT (Current Procedural Terminology) code, such as CPT code 90378 (Respiratory syncytial virus immune globulin [RSV-IgIM], for intramuscular use, 50 mg, each).

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

Claims

Claims for drug-related supplies should be submitted with the appropriate HCPCS (Healthcare Common Procedure Coding System) procedure code indicated.

Reimbursement Not Available

Topic #1890

Outpatient Mental Health and Substance Abuse Services

Payment may be denied or recouped for covered services that fail to meet program requirements. Medicaid reimbursement is also not available for noncovered services.

The following are not reimbursable as outpatient mental health services:

- Collateral interviews with persons not stipulated in DHS 107.13(2)(c), Wis. Admin. Code, and consultations, except as provided in DHS 107.06(4)(c), Wis. Admin. Code.
- Court appearances, except when necessary to defend against commitment of the member.
- Outpatient mental health services for persons with the primary diagnosis of mental retardation, except when they experience psychological problems that necessitate psychotherapeutic intervention.
- Outpatient mental health services provided in a person's home.
- Self-referrals, meaning that a provider refers a member to an agency in which the provider has a direct financial interest, or refers a member to himself or herself acting as a practitioner in private practice.

The following services are not covered outpatient substance abuse services:

- Collateral interviews and consultations, except as provided in DHS 107.06(4)(c), Wis. Admin. Code.
- Court appearances, except when necessary to defend against commitment of the member.
- Detoxification provided in a social setting, as described in DHS 75.09, Wis. Admin. Code. For more information on noncovered services, see DHS 107.03, Wis. Admin. Code.

Resources

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Archive Date:06/03/2013

Resources:Contact Information

Topic #4456

Resources Reference Guide

The Provider Services and Resources Reference Guide lists services and resources available to providers and members with contact information and hours of availability.

Provider Services and Resources

Services and resources, contact information, and hours of availability are effective after ForwardHealth implementation, unless otherwise noted.

ForwardHealth Portal	***www.forwardhealth.wi.gov/***	**24 hours a day, seven days a week**
Public and secure access to ForwardHealth information with direct link to contact Provider Services for up-to-date access to ForwardHealth programs information, including publications, fee schedules, and forms.		
WiCall Automated Voice Response System	**(800) 947-3544**	**24 hours a day, seven days a week**
WiCall, the ForwardHealth Automated Voice Response system, provides responses to the following inquiries: • Checkwrite. • Claim status. • Prior authorization. • Member enrollment.		
ForwardHealth Provider Services Call Center	**(800) 947-9627**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Time)***
To assist providers in the following programs: • BadgerCare Plus. • Medicaid. • SeniorCare. • Wisconsin Well Woman Medicaid. • Wisconsin Chronic Disease Program (WCDP). • Wisconsin Well Woman Program (WWWP). • Wisconsin Medicaid and BadgerCare Plus Managed Care Programs.		
ForwardHealth Portal Helpdesk	**(866) 908-1363**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Time)***
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal accounts, registrations, passwords, and submissions through the Portal.		
Electronic Data Interchange Helpdesk	**(866) 416-4979**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Time)***
For providers, trading partners, billing services, and clearing houses with technical questions about the following: • Electronic transactions. • Companion documents. • Provider Electronic Solutions (PES) software.		
Managed Care Ombudsman Program	**(800) 760-0001**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Time)***
To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.		
Member Services	**(800) 362-3002**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Time)***
To assist ForwardHealth members or persons calling on behalf of members with program information and requirements, enrollment, finding certified providers, and resolving concerns.		

* With the exception of state-observed holidays.

Electronic Data Interchange

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.

Enrollment Verification

Topic #469

An Overview

Providers should always verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Each enrollment verification method allows providers to verify the following prior to services being rendered:

- A member's enrollment in a ForwardHealth program(s).
- State-contracted MCO (managed care organization) enrollment.
- Medicare enrollment.
- Limited benefits categories.
- Any other commercial health insurance coverage.
- Exemption from copayments for BadgerCare Plus members.

Topic #4903

Copayment Information

If a member is enrolled in BadgerCare Plus or Wisconsin Medicaid and is exempt from paying copayments for services, providers will receive the following response to an enrollment query from all methods of enrollment verification:

- The name of the benefit plan.
- The member's enrollment dates.
- The message, "No Copay."

If a member is enrolled in BadgerCare Plus, Medicaid, or SeniorCare and is required to pay a copayment, the provider will be given the name of the benefit plan in which the member is enrolled and the member's enrollment dates for the benefit plan only.

Note: The BadgerCare Plus Core Plan may also charge different copayments for hospital services depending on the member's income level. Members identified as "BadgerCare Plus Core Plan 1" are subject to lower copayments for hospital services. Members identified as "BadgerCare Plus Core Plan 2" are subject to higher copayments for hospital services.

Topic #4901

Enrollment Verification on the Portal

The secure ForwardHealth Portal offers real-time member enrollment verification for all ForwardHealth programs. Providers will be able to use this tool to determine:

- The benefit plan(s) in which the member is enrolled.
- If the member is enrolled in a state-contracted managed care program (for Medicaid and BadgerCare Plus members).
- If the member has any other coverage, such as Medicare or commercial health insurance.
- If the member is exempted from copayments (BadgerCare Plus members only).

To access enrollment verification via the ForwardHealth Portal, providers will need to do the following:

- Go to the ForwardHealth Portal.
- Establish a provider account.
- Log into the secure Portal.
- Click on the menu item for enrollment verification.

Providers will receive a unique transaction number for each enrollment verification inquiry. Providers may access a history of their enrollment inquiries using the Portal, which will list the date the inquiry was made and the enrollment information that was given on the date that the inquiry was made. For a more permanent record of inquiries, providers are advised to use the "print screen" function to save a paper copy of enrollment verification inquiries for their records or document the transaction number at the beginning of the response, for tracking or research purposes. This feature allows providers to access enrollment verification history when researching claim denials due to enrollment issues.

The Provider Portal is available 24 hours a day, seven days a week.

Topic #4900

Entering Dates of Service

Enrollment information is provided based on a "From" DOS (date of service) and a "To" DOS that the provider enters when making the enrollment inquiry. For enrollment 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 #4899

Member Identification Card Does Not Guarantee Enrollment

Most members receive a member identification card, but possession of a program identification card does not guarantee enrollment. Periodically, members may become ineligible for enrollment, only to re-enroll at a later date. Members are told to keep their cards even though they may have gaps in enrollment periods. It is possible that a member will present a card when he or she is not enrolled; therefore, it is essential that providers verify enrollment before providing services. To reduce claim denials, it is important that providers verify the following information prior to each DOS (date of service) that services are provided:

- If a member is enrolled in any ForwardHealth program, including benefit plan limitations.

- If a member is enrolled in a managed care organization.
- If a member is in primary provider lock-in status.
- If a member has Medicare or other insurance coverage.

Topic #4898

Responses Are Based on Financial Payer

When making an enrollment inquiry through Wisconsin's EVS (Enrollment Verification System), the returned response will provide information on the member's enrollment in benefit plans based on financial payers.

There are three financial payers under ForwardHealth:

- Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and SeniorCare).
- WCDP (Wisconsin Chronic Disease Program).
- WWWP (Wisconsin Well Woman Program).

Within each financial payer are benefit plans. Each member is enrolled under at least one of the three financial payers, and under each financial payer, is enrolled in at least one benefit plan. An individual member may be enrolled under more than one financial payer. (For instance, a member with chronic renal disease may have health care coverage under the BadgerCare Plus Standard Plan and the WCDP chronic renal disease program. The member is enrolled under two financial payers, Medicaid and WCDP.) Alternatively, a member may have multiple benefits under a single financial payer. (For example, a member may be covered by the TB-Only (Tuberculosis-Related Services Only) Benefit and Family Planning Only Services at the same time, both of which are administered by Medicaid.)

Portal

Topic #4904

Claims and Adjustments Using the ForwardHealth Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, copy claims, and determine what claims are in "pay" status on the ForwardHealth Portal. Providers have the ability to search for and view the status of all their finalized claims, regardless of how they were submitted (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim through DDE (Direct Data Entry) through the secure Portal.

Topic #8524

Conducting Revalidation Via the ForwardHealth Portal

Providers can conduct revalidation online via a secure revalidation area of the ForwardHealth Portal.

Topic #5157

Cost Share Reports for Long-Term Managed Care Organizations

Individual cost share reports for long-term care MCOs (managed care organizations) that provide Family Care, Family Care Partnership, and PACE (Program of All-Inclusive Care for the Elderly) services are available via the secure area of the ForwardHealth Portal and can be downloaded as an Excel file.

Topic #4345

Creating a Provider Account

Each provider needs to designate one individual as an administrator of the ForwardHealth Portal account. This user establishes the administrative account once his or her PIN (personal identification number) is received. The administrative user is responsible for this provider account and is able to add accounts for other users (clerks) within his or her organization and assign security roles to clerks that have been established. To establish an administrative account after receiving a PIN, the administrative user is required to follow these steps:

1. Go to the ForwardHealth Portal.
2. Click the **Providers** button.
3. Click **Logging in for the first time?**.
4. Enter the Login ID and PIN. The Login ID is the provider's NPI or provider number.
5. Click **Setup Account**.
6. At the Account Setup screen, enter the user's information in the required fields.

7. Read the security agreement and click the checkbox to indicate agreement with its contents.
8. Click **Submit** when complete.

Once in the secure Provider area of the Portal, the provider may conduct business online with ForwardHealth via a secure connection. Providers may also perform the following administrative functions from the Provider area of the Portal:

- Establish accounts and define access levels for clerks.
- Add other organizations to the account.
- Switch organizations.

Refer to the Account User Guide on the Portal User Guides page of the Portal for more detailed instructions on performing these functions.

Topic #4340

Designating a Trading Partner to Receive 835 Health Care Claim Payment/Advice Transactions

Providers must designate a trading partner to receive their 835 (835 Health Care Claim Payment/Advice) transaction for ForwardHealth interChange.

Providers who wish to submit their 835 designation via the Portal are required to create and establish a provider account to have access to the secure area of the Portal.

To designate a trading partner to receive 835 transactions, providers must first complete the following steps:

- Access the Portal and log into their secure account by clicking the Provider link/button.
- Click on the Designate 835 Receiver link on the right-hand side of the secure home page.
- Enter the identification number of the trading partner that is to receive the 835 in the Trading Partner ID field.
- Click Save.

Providers who are unable to use the Portal to designate a trading partner to receive 835 transactions may call the EDI (Electronic Data Interchange) Helpdesk or submit a paper (Trading Partner 835 Designation, F-13393 (07/12)) form.

Topic #5087

Electronic Communications

The secure ForwardHealth Portal contains a one-way message center where providers can receive electronic notifications and provider publications from ForwardHealth. All new messages display on the provider's main page within the secure Portal.

Topic #5088

Enrollment Verification

The secure ForwardHealth Portal offers real time member enrollment verification for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled.

- Whether or not the member is enrolled in a state-contracted MCO (managed care organization).
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance.
- Whether or not the member is enrolled in the Pharmacy Services Lock-In Program and the member's Lock-In pharmacy, primary care provider, and referral providers (if applicable).

Using the Portal to check enrollment may be more effective than calling WiCall or the EVS (Enrollment Verification System) (although both are available).

Providers are assigned a unique enrollment verification number for each inquiry. Providers can also use the "print screen" function to print a paper copy of enrollment verification inquiries for their records.

Topic #4338

ForwardHealth Portal

Providers, members, trading partners, managed care programs, and partners have access to public *and* secure information through the ForwardHealth Portal.

The Portal has the following areas:

- Providers (public and secure).
- Trading Partners.
- Members.
- MCO (managed care organization).
- Partners.

The secure Portal allows providers to conduct business and exchange electronic transactions with ForwardHealth. The public Portal contains general information accessible to all users. Members can access general health care program information and apply for benefits online.

Topic #4441

ForwardHealth Portal Helpdesk

Providers and trading partners may call the ForwardHealth Portal Helpdesk with technical questions on Portal functions, including their Portal accounts, registrations, passwords, and submissions through the Portal.

Topic #4451

Inquiries to ForwardHealth Via the Portal

Providers are able to contact Provider Services through the ForwardHealth Portal by clicking the Contact link and entering the relevant inquiry information, including selecting the preferred method of response (i.e., telephone call or e-mail). Provider Services will respond to the inquiry by the preferred method of response indicated within five business days.

Topic #4400

Internet Connection Speed

ForwardHealth recommends providers have an Internet connection that will provide an upload speed of at least 768 Kbps and a download speed of at least 128 Kbps in order to efficiently conduct business with ForwardHealth via the Portal.

For PES (Provider Electronic Solutions) users, ForwardHealth recommends an Internet connection that will provide a download speed of at least 128 Kbps for downloading PES software and software updates from the Portal.

These download speeds are generally not available through a dial-up connection.

Topic #4351

Logging in to the Provider Area of the Portal

Once an administrative user's or other user's account is set up, he or she may log in to the Provider area of the ForwardHealth Portal to conduct business. To log in, the user is required to click the "Provider" link or button, then enter his or her username and password and click "Go" in the Login to Secure Site box at the right side of the screen.

Topic #4743

Managed Care Organization Portal

Information and Functions Through the Portal

The MCO (managed care organization) area of the ForwardHealth Portal allows state-contracted MCOs to conduct business with ForwardHealth. The Public MCO page offers easy access to key MCO information and Web tools. A log-in is required to access the secure area of the Portal to submit or retrieve account and member information which may be sensitive.

The following information is available through the Portal:

- Listing of all Medicaid-enrolled providers.
- Coordination of Benefits Extract/Insurance Carrier Master List information updated quarterly.
- Data Warehouse, which is linked from the Portal to Business Objects. The Business Objects function allows for access to MCO data for long term care MCOs.
- Electronic messages.
- Enrollment verification by entering a member ID or SSN (Social Security number) with date of birth and a "from DOS (date of service)" and a "to DOS" range. A transaction number is assigned to track the request.
- Member search function for retrieving member information such as medical status code, and managed care and Medicare information.
- Provider search function for retrieving provider information such as address, telephone number, provider ID, taxonomy code (if applicable), and provider type and specialty.
- HealthCheck information.
- MCO contact information.
- Technical contact information. Entries may be added via the Portal.

Topic #5158

Managed Care Organization Portal Reports

The following reports are generated to MCOs (managed care organizations) through their account on the ForwardHealth MCO Portal:

- Capitation Payment Listing Report.
- Cost Share Report (long-term MCOs only).
- Enrollment Reports.

MCOs are required to establish a Portal account in order to receive reports from ForwardHealth.

Capitation Payment Listing Report

The Capitation Payment Listing Report provides "payee" MCOs with a detailed listing of the members for whom they receive capitation payments. ForwardHealth interChange creates adjustment transaction information weekly and regular capitation transaction information monthly. The weekly batch report includes regular and adjustment capitation transactions. MCOs have the option of receiving both the Capitation Payment Listing Report and the 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transactions.

Initial Enrollment Roster Report

The Initial Enrollment Roster Report is generated according to the annual schedules detailing the number of new and continuing members enrolled in the MCO and those disenrolled before the next enrollment month.

Final Enrollment Roster Report

The Final Enrollment Roster Report is generated the last business day of each month and includes members who have had a change in status since the initial report and new members who were enrolled after the Initial Enrollment Roster Report was generated.

Other Reports

Additional reports are available for BadgerCare Plus HMOs, SSI HMOs, and long-term MCOs. Some are available via the Portal and some in the secure FTP (file transfer protocol).

Topic #4744

Members ForwardHealth Portal

Members can access ForwardHealth information by going to the ForwardHealth Portal. Members can search through a directory of providers by entering a ZIP code, city, or county. Members can also access all member-related ForwardHealth applications and forms. Members can use ACCESS to check availability, apply for benefits, check current benefits, and report any changes.

Topic #4344

Obtaining a Personal Identification Number

To establish an account on the ForwardHealth Portal, providers are required to obtain a PIN (personal identification number). The PIN is a unique, nine-digit number assigned by ForwardHealth interChange for the sole purpose of allowing a provider to establish a Portal account. It is used in conjunction with the provider's login ID. Once the Portal account is established, the provider will be prompted to create a username and password for the account, which will subsequently be used to log in to the Portal.

Note: The PIN used to create the provider's Portal account is not the same PIN used for revalidation. Providers will receive a

separate PIN for revalidation.

A provider may need to request more than one PIN if he or she is a provider for more than one program or has more than one type of provider enrollment. A separate PIN will be needed for each provider enrollment. Health care providers will need to supply their NPI (National Provider Identifier) and corresponding taxonomy code when requesting an account. Non-healthcare providers will need to supply their unique provider number.

Providers may request a PIN by following these steps:

1. Go to the Portal.
2. Click on the "Providers" link or button.
3. Click the "Request Portal Access" link from the Quick Links box on the right side of the screen.
4. At the Request Portal Access screen, enter the following information:
    a. Health care providers are required to enter their NPI and click "Search" to display a listing of ForwardHealth enrollments. Select the correct enrollment for the account. The taxonomy code, ZIP+4 code, and financial payer for that enrollment will be automatically populated. Enter the SSN (Social Security number) or TIN (Tax Identification Number).
    b. Non-healthcare providers are required to enter their provider number, financial payer, and SSN or TIN. (This option should only be used by non-healthcare providers who are exempt from NPI requirements).

       The financial payer is one of the following:
        - Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and Senior Care).
        - SSI (Supplemental Security Income).
        - WCDP (Wisconsin Chronic Disease Program).
        - The WWWP (Wisconsin Well Woman Program).

    c. Click **Submit**.
    d. Once the Portal Access Request is successfully completed, ForwardHealth will send a letter with the provider's PIN to the address on file.

Topic #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, he or she has complete access to all functions within the specific secure area of his or her Portal and are permitted to add, remove, and manage other individual roles.

Topic #4912

Portal Clerk Administrators

A Portal administrator may choose to delegate some of the authority and responsibility for setting up and managing the users within their ForwardHealth Portal account. If so, the Portal administrator may establish a clerk administrator. An administrator or clerk administrator can create, modify, manage or remove clerks for a Portal account. When a clerk is created, the administrator or clerk administrator must grant permissions to the clerks to ensure they have the appropriate access to the functions they will perform. A clerk administrator can only grant permissions that they themselves have. For example, if an administrator gives a clerk administrator permission only for enrollment verification, then the clerk administrator can only establish clerks with enrollment verification permissions.

Even if a Portal administrator chooses to create a clerk administrator and delegate the ability to add, modify, and remove users from the same account, the Portal administrator is still responsible for ensuring the integrity and security of the Portal account.

Topic #4913

Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their ForwardHealth Portal account. Clerks may be assigned one or many roles (i.e., claims, PA (prior authorization), member enrollment verification). Clerks do not have the ability to establish, modify, or remove other accounts.

Once a clerk account is set up, the clerk account does not have to be established again for a separate Portal account. Clerks can easily be assigned a role for different Portal accounts (i.e., different ForwardHealth enrollments). To perform work under a

different Portal account for which they have been granted authorization, a clerk can use the "switch org" function and toggle between the Portal accounts to which they have access. Clerks may be granted different authorization in each Portal account (i.e., they may do member enrollment verification for one Portal account, and HealthCheck inquires for another).

Topic #4740

Public Area of the Provider Portal

The public Provider area of the ForwardHealth Portal offers a variety of important business features and functions that will greatly assist in daily business activities with ForwardHealth programs.

Maximum Allowable Fee Schedules

Within the Portal, all maximum allowable fee schedules for Medicaid, BadgerCare Plus, and WCDP (Wisconsin Chronic Disease Program) are interactive and searchable. Providers can enter the DOS (date of service), along with other information such as procedure code, category of supplies, or provider type, to find the maximum allowable fee. Providers can also download all fee schedules.

Online Handbook

The Online Handbook is the single source for all current policy and billing information for ForwardHealth. The Online Handbook is designed to sort information based on user-entered criteria, such as program and provider type.

Revisions to policy information are incorporated into the Online Handbook in conjunction with published *Updates*. The Online Handbook also links to the ForwardHealth Publications page, an archive section where providers can research previously published *Updates*.

ForwardHealth Publications Archive Section

The ForwardHealth Publications page, available via the Quick Links box, lists *Updates*, *Update Summaries*, archives of provider Handbooks and provider guides, and monthly archives of the Online Handbook. The ForwardHealth Publications page contains both current and obsolete information for research purposes only. Providers should use the Online Handbook for current policy and procedure questions. The *Updates* are searchable by provider type or program (e.g., physician or HealthCheck "Other Services") and by year of publication.

Training

Providers can register for all scheduled trainings and view online trainings via the Portal Training page, which contains an up-to-date calendar of all available training. Additionally, providers can view Webcasts of select trainings.

Contacting Provider Services

Providers and other Portal users will have an additional option for contacting Provider Services through the Contact link on the Portal. Providers can enter the relevant inquiry information, including selecting the preferred method of response (i.e., telephone call or e-mail) the provider wishes to receive back from Provider Services. Provider Services will respond to the inquiry within five business days. Information will be submitted via a secure connection.

Online Enrollment

Providers can speed up the enrollment process for Medicaid by completing a provider enrollment application via the Portal.

Providers can then track their application by entering their ATN (application tracking number) given to them on completion of the application.

Other Business Enhancements Available on the Portal

The public Provider area of the Portal also includes the following features:

- A "What's New?" section for providers that links to the latest provider publication summaries and other new information posted to the Provider area of the Portal.
- Home page for the provider. Providers have administrative control over their Portal homepage and can grant other employees access to specified areas of the Portal, such as claims and PA (prior authorization).
- E-mail subscription service for *Updates*. Providers can register for e-mail subscription to receive notifications of new provider publications via e-mail. Users are able to select, by program and service area, which publication notifications they would like to receive.
- A forms library.

Topic #4741

Secure Area of the Provider Portal

Providers can accomplish many processes via the ForwardHealth Portal, including submitting, adjusting, and correcting claims, submitting and amending PA (prior authorization) requests, and verifying enrollment.

Claims and Adjustments Using the Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, and determine what claims are in "pay" status on the Portal. Providers have the ability to search for and view the status of all of their finalized claims, regardless of how they were submitted (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim via DDE (Direct Data Entry) through the secure Portal.

Submitting Prior Authorization and Amendment Requests Via the Portal

Nearly all service areas can submit PA requests via the Portal. Providers can do the following:

- Correct errors on PA or amendment requests via the Portal, regardless of how the PA request was originally submitted.
- View all recently submitted and finalized PA and amendment requests.
- Save a partially completed PA request and finish completing it at a later time. (*Note:* Providers are required to submit or re-save a PA request within 30 calendar days of the date the PA request was last saved.)
- View all saved PA requests and select any to continue completing or delete.
- View the latest provider review and decision letters.
- Receive messages about PA and amendment requests that have been adjudicated or returned for provider review.

Electronic Communications

The secure Portal contains a one-way message center where providers can receive electronic notifications and provider publications from ForwardHealth. All new messages display on the provider's main page within the secure Portal.

Enrollment Verification

The secure Portal offers real-time member enrollment verification for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled.
- Whether or not the member is enrolled in a state-contracted MCO (managed care organization).
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance.

Using the Portal to check enrollment may be more efficient than calling the AVR (Automated Voice Response) system or the EVS (Enrollment Verification System) (although both are available).

Providers will be assigned a unique enrollment verification number for each inquiry. Providers can also use the "print screen" function to print a paper copy of enrollment verification inquiries for their records.

Other Business Enhancements Available on the Portal

The secure Provider area of the Portal enables providers to do the following:

- Verify member enrollment.
- View RAs (Remittance Advices).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice) transaction.
- Update and maintain provider file information. Providers will have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT (electronic funds transfer).
- Track provider-submitted PA requests.

Topic #4401

System and Browser Requirements

The following table lists the recommended system and browser requirements for using the ForwardHealth Portal. PES (Provider Electronic Solutions) users should note that the Windows-based requirements noted in the table apply; PES cannot be run on Apple-based systems.

Recommended System Requirements	**Recommended Browser Requirements**
Windows-Based Systems	
Computer with at least a 500Mhz processor, 256 MB of RAM, and 100MB of free disk space	Microsoft Internet Explorer v. 6.0 or higher, or Firefox v. 1.5 or higher
Windows XP or higher operating system	
Apple-Based Systems	
Computer running a PowerPC G4 or Intel processor, 512 MB of RAM, and 150MB of free disk space	Safari, or Firefox v. 1.5 or higher
Mac OS X 10.2.x or higher operating system	

Topic #4742

Trading Partner Portal

The following information is available on the public Trading Partner area of the ForwardHealth Portal:

- Trading partner testing packets.
- Trading Partner Profile submission.
- PES (Provider Electronic Solutions) software and upgrade information.
- EDI (Electronic Data Interchange) companion guides.

In the secure Trading Partner area of the Portal, trading partners can exchange electronic transactions with ForwardHealth.

Trading partners using PES should be sure to enter the Web logon and Web password associated with the ForwardHealth trading partner ID that will be used on PES transactions. Prior to submitting transactions through PES, trading partners must also make sure their trading partner account is entered as the "Default Provider ID" on the Switch Organization page of the secure Trading Partner account on the Portal.

Training Opportunities

Topic #12757

Training Opportunities

The Provider Relations representatives conduct training sessions in a variety of formats on both program-specific and topic-specific subjects. There is no fee for attending/accessing these training sessions.

On-Site Sessions

On-site training sessions are offered at various locations (e.g., hotel conference rooms, provider facilities) throughout the state. These training sessions include general all-provider sessions, service-specific and/or topic-specific sessions, and program-specific (such as WCDP (Wisconsin Chronic Disease Program) or the WWWP (Wisconsin Well Woman Program)) sessions.

Registration is required to attend on-site sessions. Online registration is available on the Trainings page of the Providers area of the Portal.

Online (Real-Time, Web-Based) Sessions

Online (real-time, Web-based) training sessions are available and are facilitated through HP® Virtual Room. Virtual Room sessions are offered on many of the same topics as on-site sessions, but online sessions offer the following advantages:

- Participants can attend training at their own computers without leaving the office.
- Sessions are interactive as participants can ask questions during the session.
- If requested or needed, a session can be quickly organized to cover a specific topic for a small group or office.

For some larger training topics (such as ForwardHealth Portal Fundamentals), the training may be divided into individual modules, with each module focused on a particular subject. This allows participants to customize their training experience.

Registration, including an e-mail address, is required to attend Virtual Room sessions, so important session information can be sent to participants prior to the start of the session. Online registration is available on the Trainings page of the Portal.

Recorded Webcasts

Recorded Webcasts are available on a variety of topics, including some of the same topics as on-site and online sessions. Like Virtual Room sessions, some recorded Webcasts on larger training topics may be divided into individual Webcast modules, allowing participants to customize their training experience. Recorded Webcasts allow providers to view the training at their convenience on their own computers.

Registration is not required to view a recorded Webcast. Related training materials are available to download and print from the specific Webcast training session page on the Portal.

Notification of Training Opportunities

In addition to information on the Trainings page of the Portal, upcoming training session information is distributed directly through messages to providers who have secure Portal accounts and to providers who have registered for the ForwardHealth e-mail subscription service.

To sign up for a secure Portal account, click the "Request Portal Access" link in the Quick Links box on the Provider page of the Portal. To sign up for e-mail subscription, click "Register for E-mail Subscription" in the Quick Links box on the Provider page of the Portal.

WiCall

Topic #6257

Entering Letters into WiCall

For some WiCall inquries, health care providers are required to enter their taxonomy code with their NPI (National Provider Identifier). Because taxonomy codes are a combination of numbers and letters, telephone key pad combinations, shown in the table below, allow providers to successfully enter taxonomy code letters for WiCall functions (e.g., press *21 to enter an "A," press *72 to enter an "R").

Letter	Key Combination	Letter	Key Combination
A	*21	N	*62
B	*22	O	*63
C	*23	P	*71
D	*31	Q	*11
E	*32	R	*72
F	*33	S	*73
G	*41	T	*81
H	*42	U	*82
I	*43	V	*83
J	*51	W	*91
K	*52	X	*92
L	*53	Y	*93
M	*61	Z	*12

Additionally, providers may select option 9 and press "#" for an automated voice explanation of how to enter letters in WiCall.

Topic #466

Information Available Via WiCall

WiCall, ForwardHealth's AVR (Automated Voice Response) system, gathers inquiry information from callers through voice prompts and accesses ForwardHealth interChange to retrieve and "speak" back the following ForwardHealth information:

- Claim status.
- Enrollment verification.
- PA (prior authorization) status.
- Provider CheckWrite information.

Note: ForwardHealth releases CheckWrite information to WiCall no sooner than on the first state business day following the financial cycle.

Providers are prompted to enter NPI (National Provider Identifier) or provider ID and in some cases, NPI-related data, to retrieve query information.

In all inquiry scenarios, WiCall offers the following options after information is retrieved and reported back to the caller:

- Repeat the information.
- Make another inquiry of the same type.
- Return to the main menu.
- Repeat the options.

Claim Status

Providers may check the status of a specific claim by selecting the applicable program ("financial payer" option, i.e., Wisconsin Medicaid, WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program) by entering their provider ID, member identification number, DOS (date of service), and the amount billed.

Note: Claim information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Enrollment Verification

Providers may request enrollment status for any date of eligibility the member has on file by entering their provider ID and the member ID. If the member ID is unknown, providers may enter the member's date of birth and SSN (Social Security number). Additionally, the provider is prompted to enter the "From DOS" and the "To DOS" for the inquiry. The "From" DOS is the earliest date the provider requires enrollment information and the "To" DOS must be within 365 days of the "From" DOS.

Each time a provider verifies member enrollment, the enrollment verification is saved and assigned a transaction number as transaction confirmation. Providers should note the transaction number for their records.

Prior Authorization Status

Except in certain instances, providers may obtain the status of PA requests for Medicaid and WCDP via WiCall by entering their provider ID and the applicable PA number. If the provider does not know the PA number, there is an option to bypass entering the PA number and the caller will be prompted to enter other PA information such as member ID and type of service (i.e., NDC (National Drug Code), procedure code, revenue code, or ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis code.) When a match is found, WiCall reports back the PA status information, including the PA number for future reference, and the applicable program.

Information on past PAs is retained indefinitely. Paper PAs require a maximum of 20 working days from receipt to be processed and incorporated into WiCall's PA status information.

Note: PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Settlement

7

Archive Date:06/03/2013

Settlement:Cost Reporting

Topic #1896

Cost Report

Annual Settlements

To receive an annual settlement, RHCs (rural health clinics) are required to submit the following documents to ForwardHealth:

- A copy of the RHC's trial balance and filed Medicare RHC cost report. Provider-based RHCs with more than 50 beds should no longer file trial balance costs. Instead, provider-based RHCs with more than 50 beds should follow the filing instructions for the Cost Report for Independent and Provider-Based (Affiliated Hospital Having More Than 50 Beds) Rural Health Clinics form. In accordance with Medicare Cost Reporting requirements (Medi-506-98) and Wisconsin Medicaid cost settlement purposes, provider-based RHCs with more than 50 beds have been capped at the Medicare upper payment limit.
- A completed copy of the annual cost report.
- Additional documentation, as requested.

A summary of types of Wisconsin Medicaid cost report forms that are specific for the different types of RHCs is included in the following table.

Type of Rural Health Clinic	Forms to Be Submitted to Division of Health Care Access and Accountability Auditor After Calendar/Fiscal Year for Settlement Calculation to Be Scheduled	Documents Required to Be Available for Review by the Division of Health Care Access and Accountability Auditor, if not Submitted to the Division
Rural Health Clinics Affiliated with Hospitals That Have 50 or Fewer Beds	• Rural Health Clinic Statistical Data (F-11022 (07/12))form. • Rural Health Clinic Provider Staff Encounters (F-11081 (04/09))form. • Cost Report for Provider-Based Rural Health Clinics (Affiliated Hospital Having 50 or Fewer Beds) (F-11080 (04/09))form. • Rural Health Clinic Reclassification and Adjustment of Trial Balance Expenses (F-11023 (04/09))form. • Clinic trial balance. • Supporting bridge worksheets for reclassifications and adjustments.	• Medicare Cost Report. • Member encounter logs/reports for HMO activity, commercial insurance and Medicaid activity, and commercial insurance and Medicare/Medicaid activity.
Rural Health Clinics Affiliated with Hospitals That Have More Than 50 Beds	• Rural Health Statistical Data form. • Cost Report for Independent and Provider-Based (Affiliated Hospital Having More Than 50 Beds) Rural Health Clinics (F-11079 (04/09))form.	• Medicare Cost Report. • Member encounter Medicaid activity and commercial insurance and Medicare/Medicaid activity.
Independent Rural Health Clinics	• Rural Health Statistical Data form. • Cost Report for Independent and Provider-	• Medicare Cost Report. • Member encounter logs/reports for HMO

	Based (Affiliated Hospital Having More Than 50 Beds) Rural Health Clinics form.	activity, commercial insurance and Medicaid activity, commercial insurance and Medicare/Medicaid activity.

* Optional forms that are available include the Rural Health Clinic Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid HMOs (F-11025 (04/09))form and the Rural Health Clinic Medicaid-Primary Encounters Submitted to Medicaid HMOs (F-11026 (04/09))form.

The total Medicaid annual cost settlement amount is determined by multiplying the Medicaid encounter rate by the number of Medicaid encounters for the reporting period. This total is reduced by the following payments that have already been made to the RHC:

- Medicaid payments on crossover claims.
- Medicaid FFS (fee-for-service) payments.
- Member copayments received and copayments due, but not received.
- Medicaid HMO payments.
- Medicaid quarterly payments.
- Commercial insurance payments.

When determining an annual settlement, if the total reimbursement due to the RHC for allowable costs exceeds the total payments received by an RHC, the amount is a balance due to the RHC from Wisconsin Medicaid. If the total allowable costs are less than the total payments received by the RHC, the amount is a balance due to Wisconsin Medicaid by the RHC. Wisconsin Medicaid is authorized to recover overpayments, in accordance with s. 49.45(2)(a)(10), Wis. Stats., and DHS 108.02(9), Wis. Admin. Code.

Quarterly Payments

When a clinic has provided services as an RHC for 12 continuous months, it has the option of receiving quarterly payments by submitting a quarterly Medicaid Rural Health Clinic Quarterly Cost Report (F-11027 (04/09)) (referred to as "quarterly cost reports") in addition to the annual cost report. Wisconsin Medicaid's quarterly payments enable RHCs to increase cash flow throughout the year.

Report Submission

The Medicaid annual cost report and supplemental documents are due 30 days after the Medicare cost report due date, as determined in the Medicare Rural Health Clinic and Federally Qualified Health Center Manual. A 30-day extension of the Wisconsin Medicaid due date may be granted if Wisconsin Medicaid receives a written request before the original due date expires. If an extension is requested, Wisconsin Medicaid provides a written response to the request.

Failure to submit the annual cost report and supplemental documents within the specified timeframe will result in suspension of all cost settlement payments.

Quarterly cost reports must be submitted within three months of the quarter's end.

Submit annual and quarterly cost reports and requests for extensions to:

Rural Health Clinic Auditor
Bureau of Program Integrity
Division of Health Care Access and Accountability
PO Box 309
Madison WI 53701-0309

Fiscal Period and Clinic Sites

The annual cost report should cover the same fiscal period and sites as the Medicare RHC cost report.

Quarterly cost reports should cover the quarters in the RHC fiscal year.

Signature

The annual and quarterly cost reports and related Medicaid supplemental documents must be signed by the authorized individual who signs the Medicare RHC cost reports.

Topic #1892

Non-Consolidated Cost Reports

As part of the PPS (prospective payment system) rate determination, affiliated clinics or clinics under common ownership are required to submit cost reports that clearly identify the costs associated with each individual clinic. The PPS requires that rates for each individual clinic be determined using its own cost data, except for the initial PPS rate for a clinic established after clinic fiscal year 2000.

Topic #1893

Medicaid Cost Report Components

A clinic's annual settlement payment is a function of the clinic's allowable costs, which are used to generate an encounter payment rate and eligible encounters.

Medicaid-Allowable Costs

Medicaid-allowable costs are essentially those costs incurred by an RHC (rural health clinic) in the provision of RHC services. Wisconsin Medicaid determines if costs are allowable by applying Medicare cost reimbursement principles. Allowable costs are defined by federal regulations in 42 CFR Part 413 and the Medicare Provider Reimbursement Manual.

These general Medicare principles define allowable costs of hospitals and other facilities paid on a reasonable-cost or cost-related basis.

Nonallowable Costs

The following costs are not allowed in the annual or quarterly cost reports:

- Costs of services provided to members for which the RHC has not submitted a claim and has not been reimbursed by Medicaid FFS (fee-for-service) or by a Medicaid HMO.
- Direct or indirect costs of providing services to any ineligible patients at the time the services were provided.
- Group or mass information programs, health education classes, or group education activities, including media productions and publications.
- Operational costs not allowed by federal and/or state regulations.

Encounters

An RHC encounter is a face-to-face visit between a member and a Medicaid-enrolled provider to perform a covered RHC

service. To be included as an encounter on the cost report, claims for the service provided must have been submitted and paid.

Visits with more than one health professional, or multiple visits with the same health professional on the same day at one location for a single diagnosis or treatment regimen comprise a single encounter. If, after the initial encounter, the member suffers an illness or injury requiring additional diagnosis or treatment, the visit is recorded as a separate, additional encounter.

Encounter Criteria

The following criteria may define an allowable encounter:

- The service may be provided at the RHC or at any location where health center activities occur. Examples include mobile vans and private residences.
- The service provided must be a covered RHC service.

The encounter criteria are not met in the following circumstances:

- A provider participates in a community meeting or group session that is not designed to provide health services.
- The only service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program.
- A service is provided to a member who is a hospital inpatient or an emergency room patient.
- Services such as drawing blood, collecting urine specimens, performing laboratory tests, taking X-rays, or filling/dispensing prescriptions are not considered encounters.

Encounters are based on claims submitted and paid. Given that clinics have 365 days from the DOS (date of service) to submit a claim (including all corrected claims and adjustments to claims), the RHC audit will generally take place after 365 days from the end of the clinic's fiscal year. Since clinics submit their annual cost report before the 365 days have passed, there may be an adjustment to the number of encounters at the time of audit compared to the number submitted in the cost report.

Topic #1910

Overhead Expenses

Provider-based RHCs (rural health clinics) affiliated with hospitals that have 50 or fewer beds are limited to overhead expenses up to 30 percent of RHC direct costs in their cost settlement calculation of encounter rates.

Overhead expenses include, but are not limited to, office billing operations, management oversight, educational expenses, and utilities.

Adjustment Examples

The following example illustrates how the 30 percent limitation would be noted on a provider's cost report:

Example 1	
Direct RHC Expenses:	$100,000
Overhead Expenses:	+ $90,000
Total Expenses (before the 30 percent adjustment):	$190,000
Allowable Overhead Expense on Cost	$30,000 (30 percent of $100,000 direct RHC

Report:	expenses)
Total Expense for Encounter Rate Calculation:	$130,000 ($100,000 direct RHC expenses plus $30,000 adjusted overhead expenses)

In the encounter rate calculation, the provider would not be eligible for the remaining $60,000 of overhead expenses actually incurred since it exceeds the 30 percent limit. The $30,000 of allowable overhead expenses should be submitted on Line 7 ("Overhead applicable to RHC services") of the Cost Report for Provider-Based Rural Health Clinics (Affiliated Hospital Having 50 or Fewer Beds) (F-11080 (04/09))form.

If the RHC has not applied the limit to the filed cost report, the Medicaid auditor will adjust the overhead expense as stated on Line 7 to reflect the 30-percent limit on the audited version of the cost report.

An adjustment is not required for the following example:

Example 2	
Direct RHC Expenses:	$250,000
Overhead Expenses:	+ $75,000
Total Expenses:	$325,000
Allowable Overhead Expense on Cost Report:	$75,000 (30 percent of $250,000 direct RHC expenses)
Total Expense for Encounter Rate Calculation:	$325,000 ($250,000 direct RHC expenses plus $75,000 adjusted overhead expenses)

In this example, there are $75,000 of allowable RHC overhead expenses. The provider is eligible for the entire $75,000 of overhead expenses actually incurred, since it meets the 30-percent limit. The $75,000 of allowable overhead expenses should be on Line 7 of the Cost Report for Provider-Based Rural Health Clinics (Affiliated Hospital Having 50 or Fewer Beds) form.

Laboratory Costs

RHCs that are affiliated with hospitals that have 50 or fewer beds are reminded that laboratory services expenses incurred are not RHC costs and should be recorded in Section V of the Rural Health Clinic Reclassification and Adjustment of Trial Balance Expenses (F-11023 (04/09))form for overhead calculations.

Topic #3826

Medicare Part C/Medicare Advantage for Cost Settlement

Beginning with submission of 2006 cost settlement reports, RHC (Rural Health Clinics)s are required to provide claim information for claims submitted for BadgerCare Plus fee-for-service or BadgerCare Plus or Medicaid managed care programs for dual eligibles enrolled in Medicare Part C/Medicare Advantage.

If an RHC is not able to provide Medicare Part C/Medicare Advantage claim information to ForwardHealth, then cost settlements will be calculated using the weighted averaging methodology and counted as part of Medicare crossover activity.

Claim information for cost reporting purposes is defined as the following:

- Member's full name.
- Member identification number.
- DOS (date of service).
- HCPCS (Healthcare Common Procedure Coding System) or CPT (Current Procedural Terminology) procedure code.
- Amount billed.
- Reimbursement received.

Claim information submitted will be classified as Medicaid/commercial health insurance on RHC cost reports and will be subject to the same constraints as commercial health insurance.

Topic #4173

Site of Service Codes as Allowable Encounters

Site of service revenue codes received by ForwardHealth on Medicare crossover claims may be considered an allowable encounter on RHC (rural health clinic) cost reports.

Note: Site of service revenue code 0527 is not applicable for cost reporting purposes as there are currently no home health shortage areas in Wisconsin.

Revenue Code	Definition
0521	Clinic visit by member* to RHC/FQHC (federally qualified health center)
0522	Home visit by RHC/FQHC practitioner (for home address visits to the FQHC/RHC member)
0524	Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF (skilled nursing facility)
0525	Visit by RHC/FQHC practitioner to a member in an SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility
0528	Visit by RHC/FQHC practitioner to other non-RHC/FQHC site (e.g., scene of accident)

*A "member" is defined as someone who has a history of receiving medical care and whose medical record is located at a specific RHC/FQHC.

Cost Settlement Method

Topic #1895

Cost Settlement Method

The federal Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Benefits Improvement and Protection Act of 2000 repealed the reasonable cost-based reimbursement provisions of the Social Security Act and replaced them with a PPS (prospective payment system) for RHCs (rural health clinics). Under the Act, states may reimburse clinics using an alternative method if the alternative method does not reimburse less than the amount that would have been paid to the RHC under the PPS.

Approved Alternative Method

In accordance with the Act, Wisconsin Medicaid's cost settlement method is Wisconsin's approved alternative method. To ensure that the cost settlement method does not pay less than the PPS, a baseline PPS rate has been constructed for each clinic using clinic fiscal year 1999 and 2000 audited cost report data.

Rates

At the end of each clinic fiscal year, the PPS rate for a clinic's upcoming fiscal year is determined by adjusting the current PPS rate for each clinic by the following:

- The MEI (Medicare Economic Index) in effect at the end of the clinic fiscal year.
- Changes in the scope of services provided to members at the clinic based on the audited annual cost report.

Wisconsin Medicaid will notify the clinic each year of its PPS rate for the upcoming year.

Changes in Scope of Services

Staffing and service provision changes should be reported on the clinic's annual cost report as changes to FTEs (full-time employees) employed by, or contracting with, the clinic to provide RHC services and their costs. Report additions or deletions of staff providing RHC services under Section IV (Medicaid-Certified Providers Employed or Contracted by the Clinic) of the Rural Health Clinic Statistical Data (F-11022 (07/12)) form. Costs associated with these providers (i.e., salary and benefits), should be reported as part of the Facility Health Care Staff Costs on the Rural Health Clinic Reclassification and Adjustment of Trial Balance Expenses (F-11023 (04/09)) form.

Depreciation

RHCs that are affiliated with hospitals that have 50 or fewer beds report capital expenditures related to the provision of RHC services on Element 9 "Medical Equipment Depreciation" and Element 21 "Non-medical Depreciation" of the Rural Health Clinic Reclassification and Adjustment of Trial Balance Expenses. For independent RHCs, this information is gathered from the clinic's annual Medicare cost report.

The adjusted PPS rate is compared to the settlement rate for that clinic fiscal year, and Wisconsin Medicaid pays the clinic the greater of the two. For clinics for which the PPS rate is the higher of the two, Wisconsin Medicaid uses the PPS rate as the encounter rate when determining a clinic's interim and annual settlement payments using the cost settlement method.

New Clinics

For clinics that qualified for RHC status after clinic fiscal year 2000, Wisconsin Medicaid uses the PPS rate from a clinic in the same or adjacent area with a similar caseload. This rate is compared to the rate paid by the cost settlement method, and Wisconsin Medicaid pays the higher of the two rates.