Certification and Ongoing Responsibilities

1

Archive Date:11/28/2008

Certification and Ongoing Responsibilities:Certification

Border Status Providers

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

Exceptions to this policy include:

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

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

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

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

CLIA Certification or Waiver

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

CLIA Enrollment

The federal CMS sends CLIA enrollment information to ForwardHealth. The enrollment information includes CLIA identification numbers for all current laboratory sites. ForwardHealth verifies that laboratories are CLIA certified before Medicaid grants certification.

CLIA Regulations

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

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

Scope of CLIA

CLIA governs all laboratory operations including the following:

- Accreditation.
- Certification.
- Fees.
- Patient test management.
- Personnel qualifications.

- Proficiency testing.
- Quality assurance.
- Quality control.
- Records and information systems.
- Sanctions.
- Test methods, equipment, instrumentation, reagents, materials, supplies.
- Tests performed.

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

- Clinics.
- HealthCheck providers.
- Independent clinical laboratories.
- Nurse midwives.
- Nurse practitioners.
- Osteopaths.
- Physician assistants.
- Physicians.
- Rural health clinics.

CLIA Certification Types

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

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

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

Applying for CLIA Certification

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

Division of Quality Assurance

Clinical Laboratory Unit
Ste 300
2917 International La
Madison WI 53704

Providers Required to Report Changes

Providers are required to notify the Clinical Laboratory Unit in writing within 30 days of any change(s) in ownership, name, location, or director. Also, providers are required to notify the Clinical Laboratory Unit of changes in certificate types immediately and within six months when a specialty/subspecialty is added or deleted. Providers may reach the Clinical Laboratory Unit at (608) 243-2023.

Categories of Certification

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

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

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

Billing/Rendering Provider

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

Rendering Provider

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

Group Billing

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

Group Billing That Requires a Rendering Provider

Individual providers within certain groups are required to be Medicaid certified because these groups are required to identify the provider who rendered the service on claims. Claims indicating these group billing providers that are submitted without a rendering provider are denied.

Group Billing That Does Not Require a Rendering Provider

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

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

Certification Application

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

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

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

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

General Certification Information

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

Certification Requirements

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

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

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

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

Terms of Reimbursement

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

Provider Application

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

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

Previous versions of the Certification Application will be returned to the provider unprocessed. The initial Medicaid effective date will remain in effect if the provider returns the new completed application within 30 days.

Provider Agreement and Acknowledgement of Terms of Participation

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

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

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

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

Rural Health Clinics

RHCs must meet the following requirements listed in HFS 105.35, Wis. Admin. Code, for Medicaid certification:

- The clinic must be Medicare certified as an RHC.
- The clinic and clinic staff must be licensed, certified, or registered according to all appropriate state and local laws and regulations.

Wisconsin Medicaid encourages clinics to apply for Medicare and Medicaid certification simultaneously.

Completing Certification Applications

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

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

Portal Submission

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

- Fewer returned applications. Providers who apply through the Portal are taken through a series of screens that are designed to guide them through the application process. This ensures that required information is captured and therefore reduces the instances of applications returned for missing or incomplete information.
- Instant submission. At the end of the online application process, applicants instantly submit their application to ForwardHealth and are given an ATN to use in tracking the status of their application.
- Indicates documentation requirements. At the end of the online process, applicants are also given detailed instructions about what actions are needed to complete the application process. For example, the applicant will be instructed to print the provider

agreement and any additional forms that Wisconsin Medicaid must receive on paper and indicates whether supplemental information (e.g., transcripts, copy of license) is required. Applicants are also able to save a copy of the application for their records.

Paper Submission

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

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

  ForwardHealth
  Provider Maintenance
  6406 Bridge Rd
  Madison WI 53784-0006

Written requests for certification materials must include the following:

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

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

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

Definitions

According to Wisconsin Medicaid and BadgerCare Plus, an RHC:

- Is an outpatient health clinic located in a rural area designated by the U.S. HHS 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, 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.

Effective Date of Medicaid Certification

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

1. The date the provider submits his or her online provider application to ForwardHealth or contacts ForwardHealth for a paper application is the earliest effective date possible and will be the initial effective date if the following are true:
    - The provider meets all applicable licensure, certification, authorization, or other credential requirements as a prerequisite for Wisconsin Medicaid on the date of notification. Providers should not hold their application for pending licensure, Medicare, or other required certification but submit it to ForwardHealth. ForwardHealth will keep the provider's application on file and providers should send ForwardHealth proof of eligibility documents immediately, once available, for continued processing.
    - ForwardHealth received the provider agreement and any supplemental documentation within 30 days of submission of the online provider application.
    - ForwardHealth received the paper application within 30 days of the date the paper application was mailed.
2. If ForwardHealth receives the provider agreement and any applicable supplemental documents more than 30 days after the provider submitted the online application or receives the paper application more than 30 days after the date the paper application was mailed, the provider's effective date will be the date the complete application was received at ForwardHealth.
3. If ForwardHealth receives the provider's application within the 30-day deadline described above and it is incomplete or unclear, the provider will be granted one 30-day extension to respond to ForwardHealth's request for additional information. ForwardHealth must receive a response to the request for additional information within 30 days from the date on the letter requesting the missing information or item(s). This extension allows the provider additional time to obtain proof of eligibility (such as license verification, transcripts, or other certification).
4. If the provider does not send complete information within the original 30-day deadline or 30-day extension, the initial effective date will be based on the date ForwardHealth receives the complete and accurate application materials.

Group Certification Effective Dates

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

ForwardHealth
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Request for Change of Effective Date

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

Medicare Enrollment

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

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

Individual Provider Certification

For the purpose of Wisconsin Medicaid, RHCs are certified as billing providers for fee-for-service reimbursement. Each RHC rendering provider must be individually certified.

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

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

Materials for New Providers

Newly certified providers receive a CD with service-specific BadgerCare Plus and Medicaid information. On an ongoing basis, providers should refer to the Online Handbook for the most current BadgerCare Plus and Medicaid information. Future changes to policies and procedures are published in *Updates*.

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

Multiple Locations

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

Multiple Services

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

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

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

Noncertified In-State Providers

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

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

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

Notice of Certification Decision

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

Providers who meet the certification requirements will be sent a welcome letter and a copy of the signed provider agreement. Included with the letter is an attachment with important information such as effective dates, assigned provider type and specialty, and taxonomy code. This information will be used when conducting business with BadgerCare Plus, Medicaid, or SeniorCare (for example, health care providers will need to include their taxonomy code, designated by Wisconsin Medicaid, on claim submissions and requests for PA).

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

Nurse Practitioners and Nurse Midwives

Nurse practitioners and nurse midwives who treat members are required to be certified by Wisconsin Medicaid. This applies to nurse practitioners whose services are reimbursed under a physician's or clinic's billing provider NPI, 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.

Out-of-State Providers

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

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

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

following situations:

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

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

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

Outpatient Mental Health/Substance Abuse Services

Outpatient mental health and outpatient substance abuse providers must be Medicaid certified in accordance with HFS 105.22 and/or HFS 105.23, Wis. Admin. Code.

Cost Reporting for Outpatient Mental Health/Substance Abuse Services

Psychiatrists and Ph.D. psychologists who are Medicaid certified and are either employed by or under contract with an RHC may submit claims for outpatient mental health or substance abuse services under the RHC billing NPI. These services are eligible for cost-based reimbursement. Master's-level therapists and substance abuse counselors must work in a certified mental health or substance abuse clinic and may submit claims for services only through a licensed, Medicaid-certified outpatient mental health or substance abuse clinic. An RHC must become certified 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.

Provider Addresses

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

- *Practice location address and related information (formally known as physical address).* This address is where the provider's office is physically located and where records are normally kept. Additional information for the practice location includes the provider's office telephone number and telephone number for member's use. With limited exceptions, the practice location and telephone number for member's use are published in a provider directory made available to the public.
- *Mailing address.* This address is where ForwardHealth will mail general information and correspondence. Providers should indicate concise address information to aid in proper mail delivery.
- *PA address.* This address is where ForwardHealth will mail PA information.
- *Financial addresses (formally known as payee address).* Two separate financial addresses are stored in ForwardHealth interChange. The checks and RA address is where Wisconsin Medicaid will mail checks and RAs. The 1099 mailing address is where Wisconsin Medicaid will mail IRS Form 1099.

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

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

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

Provider Type and Specialty Changes

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

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

Recertification

Periodically, ForwardHealth conducts provider recertifications that require providers to update their information. Providers will be notified when they need to be recertified and will be provided with instructions on how to complete the recertification process.

Reinstating Certification

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

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

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

Tracking Certification Materials

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

Note: Providers are required to wait for the Notice of Certification Decision as official notification that certification has been approved. This notice will contain information the provider needs to conduct business with BadgerCare Plus, Medicaid, or SeniorCare; therefore, an approved or enrolled status alone does not mean the provider may begin providing or billing for services.

Tracking Through the Portal

Providers are able to track the status of a certification application through the Portal. By clicking on the "Certification Tracking Search" quick link in the Provider area of the Portal and entering their ATN, providers will receive current information on their application, such as whether it's being processed or has been returned for more information.

Tracking Through Provider Services

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

Documentation

Accounting Method

RHCs 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.

Audits

An RHC shall permit access to medical or financial records by Wisconsin Medicaid for the purposes of inspection, review, audit, or reproduction in accordance with HFS 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.

Availability of Records to Authorized Personnel

The DHCAA has the right to inspect, review, audit, and reproduce provider records pursuant to HFS 106.02(9)(e), Wis. Admin. Code. The DHCAA periodically requests provider records for compliance audits to match information against ForwardHealth's information on paid claims, PA requests, and enrollment. These records include, but are not limited to, medical/clinical and financial documents. Providers are obligated to ensure that the records are released to an authorized DHCAA staff member(s).

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

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

Also, state-contracted MCOs, including HMOs and SSI HMOs, are not reimbursed for the reproduction costs covered in their contract with the DHS.

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

Confidentiality

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

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

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

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

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

Financial Record Keeping

RHCs are required to maintain medical and financial records and documentation in accordance with HFS 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.

Financial Records

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

Medical Records

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

Member Access to Records

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

Preparation and Maintenance of Records

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

Record Retention

All providers (including RHCs 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 HFS 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 periodically reviews provider records. The DHS has the right to inspect, review, audit, and photocopy the records. Providers are required to permit access to any requested record(s), whether in written, electronic, or micrographic form.

Records Requests

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

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

Request from a Member or Authorized Person

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

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

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

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

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

1. Obtain a release signed by the member or authorized representative.
2. Furnish the requested material to the requester, marked "BILLED TO FORWARDHEALTH" or "TO BE BILLED TO FORWARDHEALTH," with a copy of the release signed by the member or authorized representative. Approval from ForwardHealth is not necessary.
3. Send a notice of the material furnished to the requester to Coordination of Benefits at the previously listed address with a copy of the signed release.

Request for Information About a Member Enrolled in a State-Contracted

Managed Care Organization

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

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

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

Request for a Statement from a Dual Eligible

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

For More Information

For additional information about requests for billing information or medical claim records, providers should call Provider Services. Providers may also write to the following address:

Division of Health Services
Estate and Casualty Recovery Section
PO Box 309
Madison WI 53701-0309

Release of Billing Information to Government Agencies

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

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

Settlement Reclassifications

RHCs 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

Accommodating Members with Disabilities

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

Change in Ownership

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

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

The following provider types require Medicare enrollment and/or DQA certification for Wisconsin Medicaid certification change in ownerships:

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

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

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

Repayment Following Change in Ownership

Medicaid-certified providers who sell or otherwise transfer their business or business assets are required to repay ForwardHealth for any erroneous payments or overpayments made to them by Wisconsin Medicaid. If necessary, the provider to whom a transfer of ownership is made will also be held liable by ForwardHealth for repayment. Therefore, prior to final transfer of ownership, the provider acquiring the business is responsible for contacting ForwardHealth to ascertain if he or she is liable under this provision.

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

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

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

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

Civil Rights Compliance (Nondiscrimination)

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

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

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

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

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

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

Providers are required to be in compliance with the previously mentioned laws as they are currently in effect or amended. Providers who employ 25 or more employees and receive $25,000 or more annually in Medicaid reimbursement are also required to comply with the DHS Affirmative Action and Civil Rights Compliance Plan requirements. Providers that employ less than 25 employees and receive less than $25,000 annually in Medicaid reimbursement are required to comply by submitting a Letter of Assurance and other appropriate forms.

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

AA/CRC Office

1 W Wilson St Rm 561
PO Box 7850
Madison WI 53707-7850

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

Title VI of the Civil Rights Act of 1964

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

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

Title VII of the Civil Rights Act of 1964

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

Federal Rehabilitation Act of 1973, Section 504

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

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

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

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

Americans with Disabilities Act of 1990

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

1. Remove barriers to make his or her goods and services available to and usable by people with disabilities to the extent that it is readily achievable to do so (i.e., to the extent that needed changes can be accomplished without much difficulty or expense).

2. Provide auxiliary aids and services so that people with sensory or cognitive disabilities have access to effective means of communication, unless doing so would fundamentally alter the operation or result in undue burdens.
3. Modify any policies, practices, or procedures that may be discriminatory or have a discriminatory effect, unless doing so would fundamentally alter the nature of the goods, services, facilities, or accommodations.
4. Ensure that there are no unnecessary eligibility criteria that tend to screen out or segregate individuals with disabilities or limit their full and equal enjoyment of the place of public accommodation.

Age Discrimination Act of 1975

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

Contracted Staff

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

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

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

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

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

Examples of Ongoing Responsibilities

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

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

- Notifying ForwardHealth of changes in ownership.
- Responding to Medicaid recertification notifications.
- Safeguarding member confidentiality.
- Verifying member enrollment.
- Keeping up-to-date with changes in program requirements as announced in ForwardHealth publications.

Keeping Information Current

Types of Changes

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

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

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

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

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

Address Changes

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

Submitting Changes in Address or Status

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

ForwardHealth Portal Submission

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

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

Paper Submission

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

Change Notification Letter

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

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

Notify Division of Quality Assurance of Changes

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

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

Legal Framework

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

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

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

The information included in the ForwardHealth Portal applies to BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid. BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid are administered by the DHS. Within the DHS, the DHCAA is directly responsible for managing these programs.

The RHC benefit is based on the RHC Services Act of 1977, Federal Public Law 95-210.

Prescription

Drugs

Most legend and certain OTC drugs are covered. (A legend drug is one whose outside package has the legend or phrase "Caution, federal law prohibits dispensing without a prescription" printed on it.) Coverage for some drugs may be restricted by one of the following policies:

- PDL.
- PA.
- Brand medically necessary drugs that require PA.
- Diagnosis-restricted drugs.
- Age-restricted and gender-restricted drugs.

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

For the most current prescription drug information, refer to the Pharmacy Data Tables. Providers may also call Provider Services for more information.

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

If a non-preferred drug is medically necessary, the prescriber is required to complete the appropriate PA/PDL form and submit it to the dispensing provider. PA/PDL forms allow the prescriber to document that the member meets one of the clinical criteria requirements for PA approval.

Clinical criteria for approval of a PA request for a non-preferred drug must include one of the following:

- A treatment failure with a preferred drug.
- A condition that prevents the use of a preferred drug(s).
- A clinically significant drug interaction with another medication and a preferred drug(s).
- An intolerable side effect experienced when using a preferred drug(s).

If the member's condition does not meet one of the clinical criterion, a PA request and peer-reviewed medical literature must be submitted to ForwardHealth, not the dispensing provider.

Prescribers are required to complete a new PA/PDL form for each non-preferred drug and provide enough clinical information so that pharmacy providers can request and obtain PA both for new prescriptions and for refills on existing prescriptions for non-preferred drugs.

If a PA/PDL form is not sent to the pharmacy provider for an existing prescription of a non-preferred drug or does not accompany a new prescription for a non-preferred drug, the pharmacy provider must contact the prescriber to obtain a completed copy of the form. Prescribers may choose to change the prescription to a preferred drug if medically appropriate for the member.

A completed PA/PDL form may be sent by mail or fax to the pharmacy provider where the prescription will be filled, or the prescriber may send a completed copy of the form with the member to the pharmacy provider. Prescribers should *not* send prescription drug PA forms directly to ForwardHealth. The pharmacy provider will use the completed form to submit a PA request to ForwardHealth. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Step Therapy for Proton Pump Inhibitor Drugs

PPI drugs on the PDL require step therapy. Step therapy requires that a member try and fail one or more preferred drugs before obtaining PA for a non-preferred drug.

Approval of a PA request for a non-preferred PPI drug can only occur in one of the following situations:

- The member has a trial and failure of or adverse reaction to a preferred PPI drug.
- The member is a child weighing less than 20 kilograms (44 lbs).
- The member is a pregnant woman.

Step Therapy for Non-Steroidal Anti-Inflammatory Drugs

NSAIDs on the PDL require the use of step therapy.

Clinical criteria for approval of a non-preferred NSAID include the following:

- The trial and failure of or an adverse reaction to a preferred NSAID.
- Risk factors, including the following:
    - The member is over 65 years of age.
    - The member has a history of ulcers or GI bleeding.
    - The member is currently taking anticoagulants.
- The member is receiving treatment for a chronic condition.

Diagnosis-Restricted Drugs

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

Brand Medically Necessary Drugs

ForwardHealth requires PA for brand medically necessary legend drugs with available generic equivalents. A list of brand medically necessary legend drugs that require PA is available.

Prescribers are required to do the following when prescribing brand medically necessary legend drugs:

- Handwrite "Brand Medically Necessary" on the prescription. (Phrases like "No Substitutes" or "N.S. " are not acceptable.) This certification must be in the prescriber's own handwriting and written directly on the prescription or on the face of each new prescription or on a separate order attached to the original prescription. Typed certification, signature stamps, or certification handwritten by someone other than the prescriber does not satisfy this requirement.
- Complete a PA/BMNA. Documentation on the PA/BMNA must indicate how the brand-name drug will prevent recurrence of the adverse or allergic reaction or therapeutic failure.
- Submit the prescription and PA/BMNA to the pharmacy where the prescription will be filled. Prescribers should *not* send prescription drug PA forms directly to ForwardHealth. The pharmacy is required to complete the PA/RF and submit the PA/BMNA, the PA/RF, and a copy of the prescription to ForwardHealth.

Prescribers are required to submit a new PA/BMNA only when prescribing a new brand medically necessary drug. Pharmacy providers may contact prescribers to request that the prescriber complete the PA/BMNA if one has not already been completed.

A prescriber is required to document clinical criteria for prescribing the brand-name drug on the PA/BMNA. Criteria for approval of the brand-name drug include the following:

- An adverse reaction to the generic drug(s).
- An allergic reaction to the generic drug(s).
- Actual therapeutic failure of the generic drug(s).

Prescribers are required to retain a copy of the completed PA/BMNA and prescription in the member's medical record.

Approval Criteria for Narrow Therapeutic Index Drugs

For certain narrow therapeutic index drugs (e.g., Clozaril, Coumadin, Dilantin, Neoral and Tegretol), an additional criteria of an *anticipated* therapeutic failure is considered. Documentation on the PA/BMNA must include the prescriber's belief that switching the member to a generic drug is likely to cause an adverse reaction.

Titration of Brand Medically Necessary Drugs

Prescribers who titrate a brand medically necessary drug for a member may request more than one strength of the drug on the PA/BMNA. Prescribers should include a prescription for each strength of the titrated brand medically necessary drug with the PA/BMNA.

Prior Authorization Requirements for Other Drugs

Although pharmacy providers are responsible for obtaining PA for the following drugs that are on the brand medically necessary list or the PDL, prescribers may be asked to provide clinical information to support the medical necessity of the drug(s):

- Alpha-1 proteinase inhibitor (Prolastin and Aralast).
- ACE inhibitors.
- Anti-obesity drugs.
- Brand-name SSRI drugs. (Generic citalopram, fluoxetine, and paroxetine do not require PA.)
- C-III and C-IV stimulants.

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

Drug manufacturers who choose to participate in state Medicaid programs are required to sign a rebate agreement with the federal CMS under the drug rebate program. ForwardHealth has identified drug manufacturers who have signed the rebate agreement. By signing the rebate agreement, the manufacturer agrees to pay ForwardHealth a rebate equal to a percentage of its "sales" to ForwardHealth.

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

ForwardHealth recognizes that the cases where it is medically necessary to provide a drug that is produced by a manufacturer who has not signed a rebate agreement. These drugs may be reimbursed when the *pharmacy* obtains PA.

In this situation, the *prescriber* is required to provide the following documentation to the pharmacy:

- A statement indicating that no other drug produced by a manufacturer who signed the rebate agreement is medically appropriate for the member.
- A statement indicating that reimbursement of the drug would be cost-effective for Medicaid.

A member request for a particular drug is not considered adequate justification for granting approval without the prescriber documenting medical necessity.

Drug Utilization Review System

The federal Omnibus Budget Reconciliation Act of 1990 (42 CFR Parts 456.703 and 456.705) called for a DUR program for all Medicaid-covered drugs to improve the quality and cost-effectiveness of recipient 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 a prescribed drug may be inappropriate or harmful to the recipient. 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 100-Day Supply Maximum

Wisconsin Medicaid allows certain drugs to be prescribed and dispensed up to a maximum of a 100-day supply as stated in HFS 107.10(3)(e), Wis. Admin. Code. These drugs are:

- Digoxin, digitoxin, and digitalis.
- Hydrochlorothiazide and chlorothiazide.
- Prenatal vitamins.
- Fluoride.
- Levothyroxine, liothyronine, and thyroid extract.
- Phenobarbital.
- Phenytoin.
- Oral contraceptives.

The following drugs may also be made available in a supply of up to 100 days:

- Insulin.
- Generic oral hypoglycemic drugs.

Member Benefits

When it is appropriate for the member's medical condition, a 100-day supply of the previously listed drugs may be beneficial to the member by:

- Aiding compliance in taking prescribed medications.
- Reducing the cost of member copayments.

- Requiring fewer trips to the pharmacy.

Prescribers of these previously listed drugs are encouraged to write prescriptions for a 100-day supply when appropriate for the Medicaid 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 100-day supply. For example, if the prescription is written for "Phenytoin 100 mg., take one capsule three times daily," the dispensing provider may dispense up to 300 capsules as long as the prescriber has indicated a 100-day supply quantity on the prescription.

Prescription Mail Delivery

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

Providers are encouraged to use the mail delivery option if requested by the member, particularly for prescriptions filled for a 100-day supply.

Noncovered Drugs

The following drugs are not covered:

- Drugs that are identified by the Food and Drug Administration as LTE or identical, related, or similar to LTE drugs.
- Drugs identified on the Wisconsin Negative Formulary.
- Drugs manufactured by companies who have not signed the rebate agreement.

SeniorCare

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

ePocrates

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

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.

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.

Tamper-Resistant Prescription Pad Requirement

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

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

Required Features for Tamper-Resistant Prescription Pads or Computer Paper

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

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

Exclusions to Tamper-Resistant Prescription Pad Requirement

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

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

Obtaining Free Prescription Pads

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

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

requirement.

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

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

72-Hour Grace Period

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

Coordination of Benefits

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

Retroactive Medicaid Eligibility

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

Penalty for Noncompliance

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

Provider Numbers

Billing Rendering Provider

Physicians, nurse practitioners, nurse midwives, psychiatrists, and psychologists are issued an NPI 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.

Group Billing National Provider Identifiers

RHCs are issued a group billing NPI and receive one reimbursement and one RA for RHC services performed by individual providers within the RHC.

Claims submitted by the RHC under the group billing NPI must identify a Medicaid-certified *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.

National Provider Identifier

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

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

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

There are two kinds of NPIs:

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

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

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

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

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

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

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

Taxonomy codes

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

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

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

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

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

ZIP Code

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

Omission of the ZIP+4 code of the provider's practice location address when it is required as additional data to identify the provider will cause claims and other transactions to be denied or delayed in processing.

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

Provider Rights

A Comprehensive Overview of Provider Rights

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

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

Ending Participation

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

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

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

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

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

ForwardHealth
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

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

Hearing Requests

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

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

Refer to HFS 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.

Annual Settlement Adjustments

An RHC 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, 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.

Limiting the Number of Members

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

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

Requesting Discretionary Waivers and Variances

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

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

Requirements

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

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

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

Application

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

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

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

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

Sanctions

Intermediate Sanctions

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

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

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

Any sanction imposed by the DHS may be appealed by the provider under HFS 106.12, Wis. Admin. Code. Providers may appeal a sanction by writing to the DHA.

Involuntary Termination

The DHS may suspend or terminate the Medicaid certification of any provider according to HFS 106.06, Wis. Admin. Code.

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

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

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

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

Sanctions for Collecting Payment from Members

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

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

Withholding Payments

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

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

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

Claims

2

Archive Date:11/28/2008

Claims:Adjustment Requests

Electronic

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

Provider Electronic Solutions Software

The DHCAA offers electronic billing software at no cost to providers. The PES software allows providers to submit electronic adjustment requests using an 837 transaction. To obtain PES software, providers may download it from the ForwardHealth Portal. Providers may also obtain the software by contacting the EDI Helpdesk.

Portal Claim Adjustments

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

Submitting Paper Attachments with Electronic Claim Adjustments

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

Responses

Providers who have a single NPI that is used for multiple certifications will receive an RA for each certification with the same NPI reported on each of the RAs. For instance, if a hospital has obtained a single NPI and the hospital has a clinic, a lab, and a pharmacy that are all certified by Medicaid, the clinic, the lab, and the pharmacy will submit separate claims that indicate the same NPI as the hospital. Separate RAs will be generated for the hospital, the clinic, the lab, and the pharmacy.

Searching for and Viewing All Claims on the Portal

All claims, including pharmacy and dental, will be available for viewing on the Portal.

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

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

Submission

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

Providers can view EOB codes and descriptions for any claim submitted to ForwardHealth on the Portal. The EOBs will be useful for providers to determine why a claim did not process successfully, so the provider may correct the error online and resubmit the claim. The EOB will appear on the bottom of the screen and will reference the applicable claim header or detail.

Direct Data Entry of Professional and Institutional Claims on the Portal

Providers can submit professional and institutional claims to ForwardHealth via DDE on the Portal. DDE is an online application that allows providers to submit claims directly to ForwardHealth. DDE is not available for dental or pharmacy claims at this time.

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.
- Admission source.
- Admission type.
- Diagnosis codes.
- Revenue codes.
- Procedure codes.
- Modifiers.

Fields within the claim form will automatically calculate totals for providers, eliminating potential clerical errors.

Electronic Claims Submission

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

- Adapts to existing systems.
- Allows flexible submission methods.

- Improves cash flow.
- Offers efficient and timely payments.
- Reduces billing and processing errors.
- Reduces clerical effort.

Electronic claims for RHC services must be submitted using either the 837P or 837I 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 document for the 837P or 837I transaction when submitting these claims.

Provider Electronic Solutions Software

The DHCAA offers electronic billing software at no cost to the provider. The PES software allows providers to submit electronic claims using the 837 transaction. To obtain PES software, providers may request the software through the ForwardHealth Portal. Providers may also obtain the software by contacting the DHCAA EDI Helpdesk.

Encounters and Claims Submission

Through the Wisconsin Medicaid RHC 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, 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 system.
- Provider Services.

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

Paper Claim Form Preparation and Data Alignment Requirements

Optical Character Recognition

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

The data alignment requirements do not apply to the Compound Drug Claim and the Noncompound Drug Claim.

Speed and Accuracy of Claims Processing

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

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

Handwritten Claims

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

Use Original Claim Forms

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

Use Laser or Ink Jet Printers

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

Alignment

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

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

The following sample claim forms demonstrate correct and incorrect alignment:

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

Clarity

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

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

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

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

Staples, Correction Liquid, and Correction Tape

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

Additional Diagnosis Codes

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

Anchor Fields

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

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

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

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

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

Paper Claim Submission

Paper claims for RHC 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.

Physician-Administered Drugs

Deficit Reduction Act of 2005

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

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

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

National Drug Codes

The U.S. FDA assigns NDCs for drugs that have received FDA approval. The NDC is an 11-digit, three segment number for a drug.

- The first segment, a five-digit labeler code that identified any firm that manufacturers, repacks, or distributes the drug. (ForwardHealth covers repackaged drugs.)
- The second segment, a four-digit code that identifies the drug's strength, dose, and formulation.
- The third segment, a two-digit code that identifies the package size.

In most cases, if an NDC is 10 digits or less, providers are required to indicate a preceding zero in the sement(s) with less that the required number of digits. If the labeler code begins with a number that is greater than orequal to one, the preceding zero may need to be indicated in the second or thir segment. In other cases, providers may need to indicate a zero at the end of a segment.

Less-Than-Effective Drugs

ForwardHealth will deny physician-administered drug claims for LTE or identical, related, or similar drugs for ForwardHealth members.

Medicare Crossover Claims

To be considered for reimbursement, NDCs and a HCPCS or CPT procedure code must be indicated on Medicare crossover claims. NDCs must be indicated on claims where Medicare is the primary payer. Medicare claims with an NDC present should automatically cross over to ForwardHealth.

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

340B Providers

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

Drugs with Signed Manufacturer Rebate Agreements

In accordance with the OBRA of 1990, also known as the Medicaid Drug Rebate Program, drug manufacturers who choose to participate in BadgerCare Plus and Medicaid are required to sign a rebate agreement with the federal government. Drug manufacturers who choose to participate in WCDP are required to sign a rebate agreement with the DHS.

BadgerCare Plus and SeniorCare will cover only the legend drugs of manufacturers who have signed rebate agreements. Non-participating manufacturers may sign rebate agreements that are effective the following quarter.

Manufacturer rebates are based on Medicaid claims data showing the quantity of each NDC dispensed to ForwardHealth members. Manufacturers may dispute the payment of drug rebates if they believe the utilization data reported to them is inaccurate. To resolve disputes, ForwardHealth verifies utilization data by having individual providers check the accuracy of claims information they submit.

Additional Information

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

- Centers for Medicare and Medicaid Services Deficit Reduction Act information page.
- National Uniform Billing Committee.
- National Uniform Claim Committee.

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

- The FDA Web site.
- The SeniorCare Drug Search Tool. (Providers may verify if an NDC and its segments are valid using this Web site.)
- The Palmetto GBA NDC crosswalk. (This Web site contains a crosswalk of J codes and NDCs to HCPCS and select CPT procedure codes.)

Submitting Paper Attachments with Electronic Claims

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

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

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

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

ForwardHealth
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Covered and Noncovered Services

3

Archive Date:11/28/2008

Covered and Noncovered Services:Codes

Diagnosis Codes

All diagnosis codes indicated on claims (and PA requests when applicable) must be the most specific ICD-9-CM diagnosis code. Providers are responsible for keeping current with diagnosis code changes. Etiology and manifestation codes may not be used as a primary diagnosis.

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

All claims submitted for RHC services must include an appropriate diagnosis code from the ICD-9-CM coding structure. Claims received without an appropriate ICD-9-CM coding structure are denied.

Procedure Codes

Use the single five-character CPT procedure code, HCPCS 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.

Covered Services and Requirements

An Overview

An RHC 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.

Benchmark Plan Coverage

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

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 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 certified and have the appropriate billing provider NPI. 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 (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.

Providers may refer to Reimbursement Not Available — Outpatient Mental Health and Substance Abuse Services for noncovered outpatient mental health and substance abuse services.

Definition of Covered Services

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

Home Health Services

Intermittent visiting nurse care and related medical services, other than drugs and biologicals, are covered as RHC services when:

- The clinic is located in an area where there is a shortage of home health agencies.
- Services are provided by an RN or LPN.
- 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 RHC Analyst.

Covered Services

For complete information on covered services and PA, providers can refer to the Home Health services area.

Nurse Practitioner and Nurse Midwife Services

Nurse practitioner and nurse midwife services are covered as RHC 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-certified 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, 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 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.

Certified nurse midwives are limited to providing the following categories of covered services:

- Family planning services.
- Laboratory services.
- Obstetric services.
- Office and outpatient visits.
- TB-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.

Obstetric Services

Providers have a choice of how and when to file claims for OB 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.

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

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

Antepartum Care Claims Submission Guide				
Total Visit(s)	**Procedure Code and Description** *		**Modifier and Description**	**Quantity**
1	99204 Office or other outpatient visit for the evaluation and management of a new patient ... Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.		TH (Obstetrical treatment/ services, prenatal or postpartum)	1.0
2	99204		TH	1.0
	99213 Office or other outpatient visit for the evaluation and management of an established patient ... Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.		TH	1.0
3	99204		TH	1.0
	99213		TH	2.0
4-6	59425	Antepartum care only; 4-6 visits		1.0
7+	59426	7 or more visits		1.0

*Refer to CPT for a complete description of procedure codes 99204 and 99213.

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

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

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 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 their 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 anetpartum 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

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 services. Other ambulatory services furnished by an RHC are not subject to the physician supervision requirements under HFS 105.35, Wis. Admin. Code.

Outpatient Mental Health/Substance Abuse Services

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

- The services must be provided by a psychiatrist, Ph.D. psychologist, HFS 61.91 to HFS 61.98, Wis. Admin. Code, a certified outpatient mental health clinic or an HFS 75.13 or HFS 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 certified by 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 certified by Wisconsin Medicaid.
- Outpatient psychotherapy services are provided in accordance with HFS 75.13(2) and HFS 75.13(3), Wis. Admin. Code.
- Outpatient substance abuse services are provided in accordance with HFS 75.13 or HFS 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 HFS 107.13(2) and HFS 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.

Providers may refer to Reimbursement Not Available — Outpatient Mental Health and Substance Abuse Services for noncovered outpatient mental health and substance abuse services.

Physician Services

Physician and Physician Assistant Services

Wisconsin Medicaid reimburses for professional services performed by Medicaid-certified physicians and physician assistants employed or under contract with an RHC. 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 guidelines, and billing instructions.

Rural Health Clinic Services Defined

RHCs 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 or LPN employed by, or under contract with, the RHC.
    - The services are furnished to a homebound member, as defined in HFS 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 certification 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-certified 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.

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-certified provider at a remote location (i.e., distant site). The services must be of sufficient audio and visual fidelity and clarity as to be functionally equivalent to a face-to-face contact. Telemedicine services do not include telephone conversations or Internet-based communication between providers or between providers and members.

All applicable HIPAA confidentiality requirements apply to telemedicine encounters.

Reimbursable Telemedicine Services

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

- Physicians and physician clinics.
- RHCs.
- FQHCs.
- Physician assistants.
- Nurse practitioners.
- Nurse midwives.
- Psychiatrists in private practice.
- Ph.D. psychologists in private practice.

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

- Office or other outpatient services (CPT procedure codes 99201-99205, 99211-99215).
- Office or other outpatient consultations (CPT codes 99241-99245).
- Initial inpatient consultations (CPT codes 99251-99255).
- Outpatient mental health services (CPT codes 90801-90849, 90862, 90875, 90876, and 90887 and HCPCS code H0046).
- Health and behavior assessment/intervention (CPT codes 96150-96152, 96154-96155).
- End-stage renal disease-related services (HCPCS codes G0308-G0309, G0311-G0315, G0317-G0318).
- Outpatient substance abuse services (HCPCS codes H0022, H0047, T1006).

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

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

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

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

Services Provided by Ancillary Providers

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

Federally Qualified Health Centers and Rural Health Clinics

Telemedicine may be reported as an encounter on the cost settlement report for both rural health clinics (RHCs) and federally qualified health clinics (FQHCs) when both of the following are true.

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

Members Located in Nursing Homes

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

Out-of-State Providers

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

Documentation Requirements

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

Eligible Members

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

Telemedicine and Enhanced Reimbursement

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

Originating Site Facility Fee

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

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

Claim Submission

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

Code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility

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

Outpatient Hospital Reimbursement

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

Store and Forward Services

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

Managed Care

4

Archive Date:11/28/2008

Managed Care:Covered and Noncovered Services

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 are exceptions to this policy:

- Prescription drugs and related services for members enrolled in the PACE and the Family Care Partnership are provided by the special managed care program.
- Physician-administered drugs are managed by the member's HMO or special managed care program.

Claims

Claims for drug-related supplies should be submitted with the appropriate HCPCS procedure code indicated.

Reimbursement

5

Archive Date:11/28/2008

Reimbursement:Amounts

Managed Care Supplemental Payments

RHCs that provide services under a contract with a BadgerCare Plus HMO 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.

Reimbursement Not Available

Reimbursement Not Available — 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 HFS 107.13(2)(c), Wis. Admin. Code, and consultations, except as provided in HFS 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 HFS 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 HFS 75.09, Wis. Admin. Code. For more information on noncovered services, see HFS 107.03, Wis. Admin. Code.

Resources

6

Archive Date:11/28/2008

Resources:Contact Information

Resources Reference Guide

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

Electronic Data Interchange

Electronic Data Interchange Helpdesk

The EDI Helpdesk assists anyone interested in becoming a trading partner with getting started and provides ongoing support pertaining to electronic transactions. Providers, billing services, and clearinghouses are encouraged to contact the EDI Helpdesk for test packets and/or technical questions.

Providers with policy questions should call Provider Services.

Enrollment Verification

An Overview

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

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

Copayment Information

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

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

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

Enrollment Verification on the Portal

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

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

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

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

Providers will receive a unique transaction number for each enrollment verification inquiry. Providers may access a history of their enrollment inquiries using the Portal, which will list the date the inquiry was made and the enrollment information that was given on the date that the inquiry was made. For a more permanent record of inquiries, providers are advised to use the "print screen" function to save a paper copy of enrollment verification inquiries for their records or document the transaction number

at the beginning of the response, for tracking or research purposes. This feature allows providers to access enrollment verification history when researching claim denials due to enrollment issues.

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

Entering Dates of Service

Enrollment information is provided based on a "From" DOS and a "To" DOS that the provider enters when making the enrollment inquiry. For enrollment inquires, a "From" DOS is the earliest date for which the provider is requesting enrollment information and the "To" DOS is the latest date for which the provider is requesting enrollment information.

Providers should use the following guidelines for entering DOS when verifying enrollment for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, or WCDP members:

- The "From" DOS may be up to one year prior to the current date.
- If the date of the request is prior to the 20th of the current month, then providers may enter a "From" DOS and "To" DOS up to the end of the current calendar month.
- If the date of the request is on or after the 20th of the current month, then providers may enter a "From" DOS and "To" DOS up to the end of the following calendar month.

For example, if the date of the request was November 15, 2008, the provider could request dates up to and including November 30, 2008. If the date of the request was November 25, 2008, the provider could request dates up to and including December 31, 2008.

Member Identification Card Does Not Guarantee Enrollment

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

- If a member is enrolled in any ForwardHealth program, including benefit plan limitations.
- If a member is enrolled in a managed care organization.
- If a member is in primary provider lock-in status.
- If a member has Medicare or other insurance coverage.

Responses Are Based on Financial Payer

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

There are three financial payers under ForwardHealth:

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

Within each financial payer are benefit plans. Each member is enrolled under at least one of the three financial payers, and

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

Portal

Claims and Adjustments Using the ForwardHealth 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 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 clain through DDE through the secure Portal.

Cost Share Reports for Long-Term Managed Care Organizations

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

Creating a Provider Account

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

1. Go to the Portal.
2. Click the "Providers" link or button.
3. Click the "Logging in for the first time" link.
4. Enter the Login ID and PIN. The Login ID is the provider's NPI or provider number.
5. Click "Setup Account."
6. At the Account Setup screen, enter the user's information in the required fields.
7. Read the security agreement and click the checkbox to indicate agreement with its contents.
8. Click "Submit" when complete.

Once in the secure Provider area of the Portal, the provider may conduct business online with ForwardHealth via a secure connection. Providers may also perform the following administrative functions from the Provider area of the Portal:

- Establish accounts and define access levels for clerks.
- Add other organizations to the account.
- Switch organizations.

A user's guide containing detailed instructions for performing these functions can be found on the Portal.

Designating a Trading Partner to Receive 835 Health

Care Claim Payment/Advice Transactions

Providers must designate a trading partner to receive their 835 transaction for ForwardHealth interChange.

Providers who wish to submit their 835 designation via the Portal are required to create and establish a provider account to have access to the secure area of the Portal.

To designate a trading partner to receive 835 transactions, providers must first complete the following steps:

- Access the Portal and log into their secure account by clicking the Provider link/button.
- Click on the Designate 835 Receiver link on the right-hand side of the secure home page.
- Enter the identification number of the trading partner that is to receive the 835 in the Trading Partner ID field.
- Click Save.

Providers who are unable to use the Portal to designate a trading partner to receive 835 transactions may call the EDI Helpdesk or submit a paper form.

Electronic Communications

The secure Portal contains a one-way message center where providers can receive electronic notifications and provider publications from ForwardHealth. All new messages display on the provider's main page within the secure Portal.

Enrollment Verification

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

- The health care program(s) in which the member is enrolled.
- Whether or not the member is enrolled in a state-contracted MCO.
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance.

Using the Portal to check enrollment may be more effective than calling WiCall or the EVS (although both will still be 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.

ForwardHealth Portal

Providers, members, trading partners, managed care programs, and partners will have access to both public and secure information through the ForwardHealth Portal.

The Portal has the following areas:

- Providers (public and secure).
- Trading Partners.
- Members.
- MCO.
- Partners.

The secure Portal allows providers to conduct business and exchange electronic transactions with ForwardHealth. The public Portal contains general information accessible to all users. Members can access general health care program information and

apply for benefits online.

ForwardHealth Portal Helpdesk

Providers and trading partners may call the ForwardHealth Portal Helpdesk with technical questions on Portal functions, including their Portal accounts, registrations, passwords, and submissions through the Portal.

Inquiries to ForwardHealth Via the Portal

Providers will be able to contact Provider Services through the ForwardHealth Portal by selecting the "Contact Us" link and entering the relevant inquiry information, including selecting the preferred method of response (i.e., telephone call or e-mail). Provider Services will respond to the inquiry by the preferred method of response indicated within five business days.

Internet Connection Speed

ForwardHealth recommends providers have an Internet connection that will provide an upload speed of at least 768 Kbps and a download speed of at least 128 Kbps in order to efficiently conduct business with ForwardHealth via the Portal.

For PES users, ForwardHealth recommends an Internet connection that will provide a download speed of at least 128 Kbps for downloading PES software and software updates from the Portal.

These download speeds are generally not available through a dial-up connection.

Logging in to the Provider Area of the Portal

Once an administrative user's or other user's account is set up, he or she may log in to the Provider area of the Portal to conduct business. To log in, the user is required to click the "Provider" link or button, then enter his or her username and password and click "Go" in the Login to Secure Site box at the right side of the screen.

Managed Care Organization Portal

Information and Functions Through the Portal

The MCO area of the ForwardHealth Portal allows state-contracted MCOs to conduct business with ForwardHealth. The Public MCO page offers easy access to key MCO information and Web tools. A log-in is required to access the secure area of the Portal to submit or retrieve account and member information which may be sensitive.

The following information is available through the Portal:

- Certified Provider Listing of all Medicaid-certified providers.
- Coordination of Benefits Extract/Insurance Carrier Master List information updated quarterly.
- Data Warehouse, which is linked from the Portal to Business Objects. The Business Objects function allows for access to MCO data for long term care MCOs.
- Electronic messages.
- Enrollment verification by entering a member ID or SSN with date of birth and a "from DOS" and a "to DOS" range. A transaction number is assigned to track the request.
- Member search function for retrieving member information such as medical status code, and managed care and Medicare information.
- Provider search function for retrieving provider information such as address, telephone number, provider ID, and taxonomy

code (if applicable), and provider type and specialty.
- HealthCheck information.
- MCO contact information.
- Technical contact information. Entries may be added via the Portal.

Managed Care Organization Portal Reports

The following reports will be generated to MCOs through their account on the ForwardHealth MCO Portal:

- Capitation Payment Listing Report.
- Cost Share Report (long-term MCOs only).
- Enrollment Reports.

MCOs are required to establish a Portal account in order to receive reports from ForwardHealth.

Capitation Payment Listing Report

The Capitation Payment Listing Report provides "payee" MCOs with a detailed listing of the members for whom they receive capitation payments. ForwardHealth interChange creates adjustment transaction information weekly and regular capitation transaction information monthly. The weekly batch report includes regular and adjustment capitation transactions. MCOs have the option of receiving both the Capitation Payment Listing Report and the 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transactions.

Initial Enrollment Roster Report

The Initial Enrollment Roster Report is generated according to the annual schedules detailing the number of new and continuing members enrolled in the MCO and those disenrolled before the next enrollment month.

Final Enrollment Roster Report

The Final Enrollment Roster Report is generated the last business day of each month and includes members who have had a change in status since the initial report and new members who were enrolled after the Initial Enrollment Roster Report was generated.

Other Reports

Additional reports are available for BadgerCare Plus HMOs, SSI HMOs, and long-term MCOs, some available via the Portal and some in the secure FTP.

Members ForwardHealth Portal

Members can access ForwardHealth information by going to the ForwardHealth Portal. Members will be able to search through a directory of providers by entering a ZIP code, city, or county. Members can also access all member-related ForwardHealth applications and forms. Members can use ACCESS to check availability, apply for benefits, check current benefits, and report any changes.

Obtaining a Personal Identification Number

To establish an account on the Portal, providers are required to obtain a PIN. The PIN is a unique, nine-digit number assigned by ForwardHealth interChange for the sole purpose of allowing a provider to establish a Portal account. It is used in conjunction with the

provider's login ID. Once the Portal account is established, the provider will be prompted to create a username and password for the account, which will subsequently be used to log in to the Portal.

A provider may need to request more than one PIN if he or she is a provider for more than one program or has more than one type of provider certification. A separate PIN will be needed for each provider certification. Health care providers will need to supply their NPI and corresponding taxonomy code when requesting an account. Non-healthcare providers will need to supply their unique provider number.

Providers may request a PIN by following these steps:

1. Go to the Portal.
2. Click on the "Providers" link or button.
3. Click the "Request Portal Access" link from the Quick Links box on the right side of the screen.
4. At the Request Portal Access screen, enter the following information:
    a. Health care providers are required to enter their NPI and click "Search" to display a listing of ForwardHealth certifications. Select the correct certification for the account. The taxonomy code, ZIP+4 code, and financial payer for that certification will be automatically populated. Enter the SSN or TIN.
    b. Non-healthcare providers are required to enter their provider number, financial payer, and SSN or TIN. (This option should only be used by non-healthcare providers who are exempt from NPI requirements).

       The financial payer is one of the following:
        - Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and Senior Care).
        - SSI.
        - WCDP.
        - The WWWP.

    c. Click **Submit**.
    d. Once the Portal Access Request is successfully completed, ForwardHealth will send a letter with the provider's PIN to the address on file.

Other Business Enhancements on the Portal

The secure Provider area of the Portal also enables providers to do the following:

- View RAs.
- Designate which trading partner is eligible to receive the provider's 835.
- Update and maintain provider file information. Providers will have the choice to indicate separate addresses for different business functions.

Portal Account Administrators

Portal administrators are responsible for requesting, creating, and managing accounts to access these features for their organization.

There must be one administrator assigned for each Portal account and all users established for that account. The responsibilities of the Portal administrator include:

- Ensuring the security and integrity of all user accounts (clerk administrators and clerks) created and associated with their Portal account.
- Ensuring clerks or clerk administrators are given the appropriate authorizations they need to perform their functions for the provider, trading partner, or MCO.
- Ensuring that clerks or clerk administrator accounts are removed/deleted promptly when the user leaves the organization.
- Ensuring that the transactions submitted are valid and recognized by ForwardHealth.

- Ensuring that all users they establish know and follow security and guidelines as required by HIPAA. As Portal administrators establish their Portal account and create accounts for others to access private information, administrators are reminded that all users must comply with HIPAA. The HIPAA privacy and security rules require that the confidentiality, integrity, and availability of PHI are maintained at all times. The HIPAA Privacy Rule provides guidelines governing the disclosure of PHI. The HIPAA Security Rule delineates the security measures to be implemented for the protection of electronic PHI. If Portal administrators have any questions concerning the protection of PHI, visit the Portal for additional information.

Portal administrators have access to all secure functions for their Portal account.

Establish an Administrator Account

All Portal accounts require an administrator account. The administrator is a selected individual who has overall responsibility for management of the account. Therefore, he or she has complete access to all functions within the specific secure area of his or her Portal and are permitted to add, remove, and manage other individual roles.

Portal Clerk Administrators

A Portal administrator may choose to delegate some of the authority and responsibility for setting up and managing the users within their Portal account. If so, the Portal administrator may establish a clerk administrator. An administrator or clerk administrator can create, modify, manage or remove clerks for a Portal account. When a clerk is created, the administrator or clerk administrator must grant permissions to the clerks to ensure they have the appropriate access to the functions they will perform. A clerk administrator can only grant permissions that they themselves have. For example, if an administrator gives a clerk administrator permission only for enrollment verification, then the clerk administrator can only establish clerks with enrollment verification permissions.

Even if a Portal administrator chooses to create a clerk administrator and delegate the ability to add, modify, and remove users from the same account, the Portal administrator is still responsible for ensuring the integrity and security of the Portal account.

Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their Portal account. Clerks may be assigned one or many roles (i.e., claims, PA, enrollment verification). Clerks do not have the ability to establish, modify, or remove other accounts.

Once a clerk account is set up, the clerk account does not have to be established again for a separate Portal account. Clerks can easily be assigned a role for different Portal accounts (i.e., different ForwardHealth certifications). To perform work under a different Portal account for which they have been granted authorization, a clerk can use the "switch org" function and toggle between the Portal accounts to which they have access. Clerks may be granted different authorization in each Portal account (i.e., they may do enrollment verification for one Portal account, and HealthCheck inquires for another).

Public Area of the Provider Portal

The public Provider area of the Portal offers a variety of important business features and functions that will greatly assist in daily business activities with ForwardHealth programs.

Maximum Allowable Fee Schedules

Within the Portal, all fee schedules for Medicaid, BadgerCare Plus, and WCDP are interactive and searchable. Providers can enter the DOS, along with other information such as procedure code, category of supplies, or provider type, to find the maximum allowable fee. Providers can also download all fee schedules.

Online Handbook

The Online Handbook is the single source for *all* policy and billing information for ForwardHealth located in one centralized place. The Online Handbook is designed to sort information based on user-entered criteria, such as program and provider type.

Revisions to information are incorporated immediately after policy changes have been issued in *Updates*. The Online Handbook also includes an archive section, so providers can research past policy changes.

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 Us" link on the Portal. Providers can enter the relevant inquiry information, including selecting the preferred method of response (i.e., telephone call or e-mail) the provider wishes to receive back from Provider Services. Provider Services will respond to the inquiry within five business days. Information will be submitted via a secure connection.

Online Certification

Providers can speed up the certification process for Medicaid by completing a provider certification application via the Portal. Providers can then track their application by entering their ATN given to them on completion of the application.

Other Business Enhancements Available on the Portal

The public Provider area of the Portal also includes the following features:

- A "What's New?" section for providers that links to the latest provider publication summaries and other new information posted to the Provider area of the Portal.
- Home page for the provider. Providers have administrative control over their Portal homepage and can grant other employees access to specified areas of the Portal, such as claims and PA.
- E-mail subscription service for *Updates*. Providers can sign up to receive notifications of new provider publications via e-mail. Users are able to select, by program and service area, which publication notifications they would like to receive.
- A forms library.

Secure Area of the Provider Portal

Providers can accomplish many processes via the Portal, including submitting, adjusting, and correcting claims, submitting and amending PA requests, and verifying enrollment.

Claims and Adjustments Using the Portal

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

Providers can submit an individual claim or adjust a claim via DDE through the secure Portal.

Submitting Prior Authorization and Amendment Requests Via the Portal

Nearly all service areas can submit PAs via the Portal. Providers can do the following:

- Correct errors on PAs or amendment requests via the Portal, regardless of how the PA was originally submitted.
- View all recently submitted and finalized PA and amendment requests.
- View the latest provider review and decision letters.
- Receive messages about PA and amendment requests that have been adjudicated or returned for provider review.

Electronic Communications

The secure Portal contains a one-way message center where providers can receive electronic notifications and provider publications from ForwardHealth. All new messages display on the provider's main page within the secure Portal.

Enrollment Verification

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

- The health care program(s) in which the member is enrolled.
- Whether or not the member is enrolled in a state-contracted MCO.
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance.

Using the Portal to check enrollment may be more efficient than calling the AVR system or the EVS (although both will still be 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 also enables providers to do the following:

- View RAs.
- Designate which trading partner is eligible to receive the provider's 835.
- Update and maintain provider file information. Providers will have the choice to indicate separate addresses for different business functions.

System and Browser Requirements

The following table lists the recommended system and browser requirements for using the Portal. PES users should note that the Windows-based requirements noted in the table apply; PES cannot be run on Apple-based systems.

Recommended System Requirements	Recommended Browser Requirements
Windows-Based Systems	
Computer with at least a 500Mhz processor, 256 MB of RAM, and 100MB of free disk space	Microsoft Internet Explorer v. 6.0 or higher, or Firefox v. 1.5 or higher
Windows XP or higher operating system	

Apple-Based Systems	
Computer running a PowerPC G4 or Intel processor, 512 MB of RAM, and 150MB of free disk space	Safari, or Firefox v. 1.5 or higher
Mac OS X 10.2.x or higher operating system	

Trading Partner Portal

The following information is available on the public Trading Partner area of the Portal:

- Trading partner testing packets.
- Trading Partner Profile submission.
- PES software and upgrade information.
- EDI companion documents.

In the secure Trading Partner area of the Portal, trading partners can exchange electronic transactions with ForwardHealth.

WiCall

Information Available Via WiCall

WiCall, ForwardHealth's AVR system, gathers inquiry information from callers through voice prompts and accesses ForwardHealth interChange to retrieve and "speak" back the following ForwardHealth information:

- Claim status.
- Enrollment verification.
- PA status.
- Provider CheckWrite information.

Providers are prompted to enter NPI or provider ID and in some cases, NPI-related data, to retrieve query information.

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.

In all inquiry scenarios, WiCall offers the following options after information is retrieved and reported back to the caller:

- Repeat the information.
- Make another inquiry of the same type.
- Return to the main menu.
- Repeat the options.

Claim Status

Providers may check the status of a specific claim by selecting the applicable program ("financial payer" option, i.e., Wisconsin Medicaid, WCDP, or WWWP by entering their provider ID, member identification number, DOS, and the amount billed.

Note: Claim information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Enrollment Verification

Providers may request enrollment status by entering their provider ID and the member ID. If the member ID is unknown, providers may enter the member's date of birth and SSN. Additionally, the provider is prompted to enter the "From DOS" and the "To DOS" for the inquiry. The "From DOS" information is available up to one year back from the current date. The provider is also informed if the member is not subject to copayments.

Each time a provider verifies member enrollment, the enrollment verification is saved and assigned a transaction number as transaction confirmation. Providers should note the transaction number for their records.

Prior Authorization Status

Except in certain instances, providers may obtain the status of PA requests for Medicaid and WCDP via WiCall by entering their provider ID and the applicable PA number. If the provider does not know the PA number, there is an option to bypass entering the PA number and the caller will be prompted to enter other PA information such as member ID and type of service (i.e., NDC/procedure code, revenue code, or ICD-9-CM diagnosis code.) When a match is found, WiCall reports back the PA status information, including the PA number for future reference, and the applicable program.

Note: PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Settlement

7

Archive Date:11/28/2008

Settlement:Cost Reporting

Cost Report

Annual Settlements

To receive an annual settlement, RHCs 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 form. • Rural Health Clinic Provider Staff Encounters form. • Cost Report for Provider-Based Rural Health Clinics (Affiliated Hospital Having 50 or Fewer Beds) form. • Rural Health Clinic Reclassification and Adjustment of Trial Balance Expenses 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 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-Based (Affiliated Hospital Having More Than 50 Beds) Rural Health Clinics form.	• Medicare Cost Report. • Member encounter logs/reports for HMO 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 form and the Rural Health Clinic Medicaid-Primary Encounters Submitted to Medicaid HMOs 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 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 HFS 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 (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.

Non-Consolidated Cost Reports

As part of the PPS 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.

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 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 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-certified 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 provider consults with a member over the telephone.
- 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 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.

Overhead Expenses

Provider-based RHCs 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 Report:	$30,000 (30 percent of $100,000 direct RHC 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) 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 form for overhead calculations.

Medicare Part C/Medicare Advantage for Cost Settlement

Beginning with submission of 2006 cost settlement reports, RHCs 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.
- HCPCS or CPT 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.

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 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	Definition

Code	
0521	Clinic visit by member* to RHC/FQHC
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
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

Cost Settlement Method

The federal Medicare, Medicaid, and SCHIP 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 for RHCs. 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 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 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 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 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.