Claims

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Archive Date:05/01/2018

Claims:Responses

Topic #13437

ForwardHealth-Initiated Claim Adjustments

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

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

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

Submission

Topic #16937

Electronic Claims and Claim Adjustments with Other Commercial Health Insurance Information

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

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

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

Adjustments to Claims Submitted Prior to June 16, 2014

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

Topic #10637

Reimbursement Reduction for Most Paper Claims

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

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

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

The reimbursement reduction applies to the following paper claims:

- 1500 Health Insurance Claim Form ((02/12)).
- UB-04 (CMS 1450) Claim Form.
- Compound Drug Claim (F-13073 (04/17)) form.
- Noncompound Drug Claim (F-13072 (04/17)) form.

Exceptions to Paper Claim Reimbursement Reduction

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

- In-state emergency providers.
- Out-of-state providers.
- Medicare crossover claims.
- Any claims that ForwardHealth requires additional supporting information to be submitted on paper. For example:
  - Hysterectomy claims must be submitted along with an Acknowledgment of Receipt of Hysterectomy Information (F-01160 (06/13)) form.
  - Sterilization claims must be submitted along with a paper Consent for Sterilization (F-01164 (10/08)) form.
  - Claims submitted to Timely Filing appeals must be submitted on paper with a Timely Filing Appeals Request (F-13047 (08/15)) form.
  - In certain circumstances, drug claims must be submitted on paper with a Pharmacy Special Handling Request (F-13074 (07/12)) form.
  - Claims submitted with four or more NDCs (National Drug Codes) for compound and noncompound drugs with specific and non-specific HCPCS (Healthcare Common Procedure Coding System) procedure codes.

Topic #186

Submitting Claims

Providers should follow their service-specific claim instructions when submitting claims for services provided to members receiving the TB-Only (Tuberculosis-Related Services-Only) Benefit.

Coordination of Benefits

2

Archive Date:05/01/2018

Coordination of Benefits:Commercial Health Insurance

Topic #18497

Explanation of Medical Benefits Form Requirement

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

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

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

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

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

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

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

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

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

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

Covered and Noncovered Services

3

Archive Date:05/01/2018

Covered and Noncovered Services:Codes

Topic #187

Diagnosis Codes

With the exception of independent laboratory providers, portable X-ray providers, and pharmacy providers, providers should indicate a TB (tuberculosis)-related ICD (International Classification of Diseases) diagnosis code as the primary diagnosis when submitting claims for TB-related services. Wisconsin Medicaid has identified commonly used allowable diagnosis codes for services provided to members receiving the TB-Only (Tuberculosis-Related Services-Only) Benefit — listed in the table below. Providers are reminded that this list is not exhaustive and intended to provide examples only. Providers should submit the most appropriate diagnosis code as supported in the medical record. Providers are responsible for keeping current with diagnosis code changes. Claims submitted that do not include a TB-related diagnosis code as the primary diagnosis may be denied. Providers may use additional ICD diagnosis codes in the secondary positions as appropriate.

This list is not an exhaustive list of allowable TB diagnosis codes. Other diagnosis codes representing TB may be appropriate for submission.

Diagnosis Codes	Descriptions
A15.0	Tuberculosis of lung
A18.4	Tuberculosis of skin and subcutaneous tissue
A18.2	Tuberculous peripheral lymphadenopathy
A18.03	Tuberculosis of other bones
A18.01	Tuberculosis of spine
A18.02	Tuberculous arthritis of other joints
A15.6	Tuberculous pleurisy
A18.11	Tuberculosis of kidney and ureter
A18.84	Tuberculosis of heart
A18.83	Tuberculosis of digestive tract organs, not elsewhere classified
A17.81	Tuberculoma of brain and spinal cord
A18.89	Tuberculosis of other sites
R76.11	Nonspecific reaction to tuberculin skin test without active tuberculosis
R76.12	Nonspecific reaction to cell mediated immunity measurement of gamma interferon antigen response without active tuberculosis
Z20.1	Contact with and (suspected) exposure to tuberculosis
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out
Z86.11	Personal history of tuberculosis

Service-specific information about diagnosis codes is available for independent laboratory providers, portable X-ray providers, and pharmacy providers.

Topic #185

Place of Service Codes

Services that are reimbursable through the TB-Only (Tuberculosis-Related Services-Only) Benefit must be provided in an allowable POS (place of service).

Place of Service Code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
15	Mobile Unit
19	Off Campus — Outpatient Hospital
20	Urgent Care Facility
22	On Campus — Outpatient Hospital
23	Emergency Room — Hospital
34	Hospice
50	Federally Qualified Health Center
60	Mass Immunization Center
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

Topic #364

Procedure Codes

Information is available for DOS (dates of service) before January 1, 2018.

Wisconsin Medicaid has identified commonly used allowable procedure codes for services provided to members receiving the TB-Only (Tuberculosis-Related Services-Only) Benefit. Providers are required to use the procedure code that best describes the service and level of service provided.

Procedure Code	Description	Allowable Providers
H0033*	Oral medication administration, direct observation (one unit is 15 minutes)	• FQHCs (federally qualified health centers). • HealthCheck screeners. • Home health agencies. • Nurse midwives. • Nurse practitioners. • Physician assistants. • Physician clinics. • Physicians. • PNCC (Prenatal Care Coordination) providers.
S9445**	Patient education, not otherwise classified, non-physician provider, individual, per session	
99401***	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes	
99402***	approximately 30 minutes	
99403***	approximately 45 minutes	
99404***	approximately 60 minutes	
71045	Radiological examination, chest; single view	• Family planning clinics. • FQHCs. • HealthCheck screeners. • Nurse midwives. • Nurse practitioners. • Outpatient hospitals. • Physician assistants. • Physician clinics. • Physicians. • Portable X-ray providers. • PNCC providers.
71046	Radiological examination, chest; 2 views	
86480	Tuberculosis test, cell mediated immunity antigen response measurement; gamma interferon	• FQHCs. • Independent laboratories. • Nurse practitioners. • Outpatient hospitals. • Physician assistants. • Physician clinics. • Physicians.

86481	Tuberculosis test, cell mediated immunity antigen response measurement; enumeration of gamma interferon-producing T-cells in cell suspension	• FQHCs. • HealthCheck screeners. • Home health agencies. • Independent laboratories. • Nurse midwives. • Nurse practitioners. • Physician assistants. • Physician clinics. • Physicians. • PNCC providers.
86580	Skin test; tuberculosis, intradermal	• Family planning clinics. • FQHCs. • HealthCheck screeners. • Independent laboratories. • Nurse midwives. • Nurse practitioners. • Outpatient hospitals. • Physician assistants. • Physician clinics. • Physicians. • PNCC providers.
89220	Sputum, obtaining specimen, aerosol induced technique (separate procedure)	• FQHCs. • HealthCheck screeners. • Independent laboratories. • Nurse midwives. • Nurse practitioners. • Outpatient hospitals. • Physician assistants. • Physician clinics. • Physicians. • PNCC providers.
	Demonstration and/or evaluation of patient utilization of	• FQHCs. • HealthCheck screeners. • Nurse midwives. • Nurse practitioners.

94664	an aerosol generator, nebulizer, metered dose inhaler or IPPB device (94664 can be reported one time only per day of service)	• Outpatient hospitals. • Physician assistants. • Physician clinics. • Physicians. • PNCC providers.
99000	Handling and/or conveyance of specimen for transfer from the office to a laboratory	• Family planning clinics. • FQHCs. • HealthCheck screeners. • Independent laboratories. • Nurse midwives. • Nurse practitioners. • Outpatient hospitals. • Physician assistants. • Physician clinics. • Physicians. • PNCC providers.

* Procedure code H0033 may be billed for the same DOS (date of service) as 99401, 99402, 99403, 99404, and S9445 for symptom treatment monitoring. Procedure code H0033 is limited to 12 units per DOS. One unit is equal to 15 minutes.

** Procedure codes 99401, 99402, 99403, and 99404 are not reimbursable on the same DOS as S9445. A quantity of "1" indicates a complete service for procedure code S9445. Providers are limited to a quantity of one per day.

*** A quantity of "1" indicates a complete service for these procedure codes. Providers have a limit of one quantity per day.

Topic #643

Unlisted Procedure Codes

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

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

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

Unlisted Codes That Do Not Require Prior Authorization or Additional

Supporting Documentation

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

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

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

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

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

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

Unlisted Codes That Do Not Require Prior Authorization

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

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

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

How to Submit Claims and Related Documentation

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

- If submitting on paper using the 1500 Health Insurance Claim Form ((02/12)), the provider may do either of the following:
  - Include supporting information/description in Item Number 19 of the claim form.
  - Include supporting documentation on a separate paper attachment. This option should be used if Item Number 19 on the 1500 Health Insurance Claim Form does not allow enough space for the description or when billing multiple unlisted procedure codes. Providers should indicate "See Attachment" in Item Number 19 of the claim form and send the supporting documentation along with the claim form.
- If submitting electronically using DDE (Direct Data Entry) on the Portal, PES (Provider Electronic Solutions) software, or 837 (837 Health Care Claim) electronic transactions, the provider may do one of the following:
  - Include supporting documentation in the Notes field. The Notes field is limited to 80 characters.

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

Topic #830

Valid Codes Required on Claims

ForwardHealth requires that all codes indicated on claims and PA (prior authorization) requests, including diagnosis codes, revenue codes, HCPCS (Healthcare Common Procedure Coding System) codes, and CPT (Current Procedural Terminology) codes be valid codes. Claims received without valid diagnosis codes, revenue codes, and HCPCS or CPT codes will be denied; PA requests received without valid codes will be returned to the provider. Providers should refer to current national coding and billing manuals for information on valid code sets.

Code Validity

In order for a code to be valid, it must reflect the highest number of required characters as indicated by its national coding and billing manual. If a stakeholder uses a code that is not valid, ForwardHealth will deny the claim or return the PA request, and it will need to be resubmitted with a valid code.

Code Specificity for Diagnosis

All codes allow a high level of detail for a condition. The level of detail for ICD (International Classification of Diseases) diagnosis codes is expressed as the level of specificity. In order for a code to be valid, it must reflect the highest level of specificity (i.e., contain the highest number of characters) required by the code set. For some codes, this could be as few as three characters. If a stakeholder uses an ICD diagnosis code that is not valid (i.e., not to the specific number of characters required), ForwardHealth will deny the claim or return the PA request, and it will need to be resubmitted with a valid ICD diagnosis code.

Covered Services and Requirements

Topic #144

A Comprehensive Overview

Members of the TB-Only (Tuberculosis-Related Services-Only) Benefit are enrolled *only* for covered TB (tuberculosis)-related outpatient services. These services include:

- Drugs.
- Physician services.
- Laboratory services.
- Radiology services.
- Case management services.
- Transportation services.
- DOT (directly observed therapy).
- Symptom and treatment monitoring.
- Patient education and anticipatory guidance.

To receive reimbursement through the TB-Only Benefit, the services provided must relate to the diagnosis, treatment, or complications of TB and may vary depending on the member's condition. For example, services may be provided and reimbursed through the TB-Only Benefit when necessary due to side effects from drugs prescribed to treat TB.

Topic #168

Case Management Services

Case management services help a member and, when appropriate, the member's family gain access to, coordinate, or monitor necessary medical, social, educational, vocational, and other services. All Medicaid-covered case management services may be reimbursed through the TB-Only (Tuberculosis-Related Services-Only) Benefit.

Allowable Providers

Medicaid case management services providers may provide TB (tuberculosis)-related case management services and receive reimbursement through the TB-Only Benefit. In addition, providers must be Medicaid-enrolled for the target group "individuals infected with TB." Target populations may be added using the demographic maintenance tool.

Topic #44

Definition of Covered Services

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

Topic #164

Directly Observed Therapy

Full-benefit Medicaid members and members of the TB-Only (Tuberculosis-Related Services-Only) Benefit are eligible for DOT (directly observed therapy). These services may be provided to encourage adherence to the member's treatment program, including completion of the course of a prescribed drug.

DOT may be provided by a health care provider or other designated person to ensure that the member ingests TB (tuberculosis) medication as prescribed in his or her treatment plan.

The need for DOT services, including the treatment course as indicated in the treatment plan, must be documented in the member's medical record. Family members should not be used for DOT. The provider may not bill for services rendered by family members or be reimbursed for family member time.

Providers are required to indicate procedure code H0033 on claims only when the direct observation is to ensure that the member ingests his or her TB medication. A valid TB related diagnosis must be indicated on claims billing procedure code H0033.

Reimbursement rates for DOT include travel time and delivery of medications. Therefore, travel time and delivery of medications are not separately reimbursable.

Limitation

Procedure code H0033 is limited to 12 units per DOS. One unit is equal to 15 minutes. This service is reimbursable on the same DOS as 99401 — 99404 (TB symptom and treatment monitoring) or as S9445 (patient education and anticipatory guidance). However, codes 99401 — 99404 are not reimbursable for the same DOS as S9445.

Allowable Providers

Wisconsin Medicaid has identified providers who may provide TB-related DOT.

Topic #42

Drugs

TB (tuberculosis)-related drugs include, but are not limited to, the following:

- Capreomycin.
- Cycloserine.
- Ethambutol.
- Ethionamide.
- Isoniazid.
- Kanamycin.
- Pyrazinamide.
- Pyridoxine.
- P-aminosalicylic acid.
- Pyridoxine tablets (Vitamin B_6 — 10, 25, 50, and 100 mg).
- Rifabutin.
- Rifamate®.
- Rifampin.
- Rifater®.
- Streptomycin.

If the pharmacy provider or dispensing physician verifies with the member that the member's need for the drug is TB related, other drugs may be reimbursed through the TB-Only (Tuberculosis-Related Services-Only) Benefit.

Allowable Providers

Medicaid pharmacy providers and dispensing physicians may dispense TB-related drugs and receive reimbursement through the TB-Only Benefit.

Topic #43

Laboratory Services

TB (tuberculosis)-related laboratory services, including services to diagnose or confirm the presence of TB infection or disease, may be reimbursed through the TB-Only (Tuberculosis-Related Services-Only) Benefit.

Allowable Providers

Wisconsin Medicaid has identified providers who may provide TB-related laboratory services and receive reimbursement through the TB-Only Benefit.

Topic #189

Patient Education and Anticipatory Guidance

Full-benefit Medicaid members and members receiving the TB-Only (Tuberculosis-Related Services-Only) Benefit have coverage for patient education and anticipatory guidance. These services may be provided to encourage adherence to the member's treatment program, including completion of the course of a prescribed drug.

Limited patient education and anticipatory guidance may include providing information about TB (tuberculosis) infection or disease, diagnostic tests, treatment, benefits of adherence to treatment, and follow-up care.

Reimbursement rates for patient education and anticipatory guidance include travel time. Therefore, travel time is not separately reimbursable.

Providers should indicate procedure code S9445 when submitting claims for patient education and anticipatory guidance. A quantity of "1" indicates a complete service. Providers are limited to a quantity of one per day.

Allowable Providers

Wisconsin Medicaid has identified providers who may provide TB-related patient education and anticipatory guidance.

Topic #166

Physician Services

TB (tuberculosis)-related physician services, including office visits, may be reimbursed through the TB-Only (Tuberculosis-Related Services-Only) Benefit.

Allowable Providers

Medicaid physicians, physician clinics, physician assistants, and nurse practitioners may provide TB-related physician services within their scope of practice and receive reimbursement through the TB-Only Benefit.

Topic #165

Radiology Services

TB (tuberculosis)-related radiology services may be reimbursed through the TB-Only (Tuberculosis-Related Services-Only) Benefit.

Allowable Providers

Wisconsin Medicaid has identified providers who may provide TB-related radiology services and receive reimbursement through the TB-Only Benefit.

Topic #188

Symptom and Treatment Monitoring

Full-benefit Medicaid members and members receiving the TB-Only (Tuberculosis-Related Services-Only) Benefit are covered for symptom and treatment monitoring. These services may be provided to encourage adherence to the member's treatment program, including completion of the course of a prescribed drug.

TB (tuberculosis) symptom and treatment monitoring includes the following:

- Clinical assessment of TB.
- Incorporating a history of treatment for TB infection or disease.
- Monitoring adherence to the member's treatment program.
- Monitoring signs and symptoms of the TB infection or disease.
- Monitoring adverse reactions.

Reimbursement rates for TB symptom and treatment monitoring include travel time. Therefore, travel time is not separately reimbursable.

Providers should indicate one of the following procedure codes with a quantity of "1" when submitting claims for TB symptom and treatment monitoring:

- 99401.
- 99402.
- 99403.
- 99404.

A quantity of "1" indicates a complete service for the above procedure codes. Providers have a limit of one quantity per day.

Allowable Providers

Wisconsin Medicaid has identified providers who may provide TB symptom and treatment monitoring.

Topic #167

Transportation Services

Transportation to receive TB (tuberculosis)-related services is covered for members receiving the TB-Only (Tuberculosis-Related Services-Only) Benefit if they have no other way to receive a ride. NEMT (non-emergency medical transportation) services are provided through MTM, Inc. (Medical Transportation Management, Inc.), the transportation management system contracted with the DHS (Department of Health Services). Providers may be asked to verify that the member received covered services at their site on a particular date.

Refer to the NEMT Online Handbook for more information.

Noncovered Services

Topic #184

Noncovered Services

Inpatient hospital services and nursing home services are not covered through the TB-Only (Tuberculosis-Related Services-Only) Benefit.

In addition, services not related to the treatment or complications of TB (tuberculosis) are not covered through the TB-Only Benefit. For example, routine dental services and substance abuse day treatment services are not covered through this limited benefit category.

Managed Care

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Archive Date:05/01/2018

Managed Care:Covered and Noncovered Services

Topic #16197

Care4Kids Program Benefit Package

Covered Services

Members enrolled in the Care4Kids program are eligible to receive all medically necessary services covered under Wisconsin Medicaid; however, Care4Kids will have the flexibility to provide services in a manner that best meets the unique needs of children in out-of-home care, including streamlining PA (prior authorization) requirements and offering select services in home settings. Members will also be allowed to go to any Medicaid-enrolled provider for emergency medical services or family planning services.

Noncovered Services

The following services are not provided as covered benefits through the Care4Kids program, but can be reimbursed for eligible Medicaid members on a fee-for-service basis:

- Behavioral treatment.
- Chiropractic services.
- CRS (Community Recovery Services).
- CSP (Community Support Programs).
- CCS (Comprehensive Community Services).
- Crisis intervention services.
- Directly observed therapy for individuals with tuberculosis.
- MTM (Medication therapy management).
- NEMT (Non-emergency medical transportation) services.
- Prescription and over-the-counter drugs and diabetic supplies dispensed by the pharmacy.
- Provider-administered drugs and their administration, and the administration of Synagis.
- SBS (School-based services).
- Targeted case management.

Children's Hospital of Wisconsin will establish working relationships, defined in writing through a memorandum of understanding, with providers of the following services:

- CSP.
- CCS.
- Crisis intervention services.
- SBS.
- Targeted case management services.

Providers of these services must coordinate with Care4Kids to help assure continuity of care, eliminate duplication, and reduce fragmentation of services.

Managed Care Information

Topic #16177

Care4Kids Program Overview

Care4Kids is a health care program for children and youth in out-of-home care in Wisconsin. The Care4Kids program will offer comprehensive, coordinated services that are intended to improve the quality and timeliness of and access to health services for these children.

The Care4Kids program will serve children in out-of-home care placements (other than residential care centers) in Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties. Member participation will be voluntary and enrollment will be allowed to continue for up to 12 months after the child leaves the out-of-home care system, as long as the child remains Medicaid-eligible and resides within one of the six counties.

Care4Kids is required to provide at least the same benefits as those provided under fee-for-service arrangements.

Program Administration

Children's Hospital of Wisconsin is currently the only integrated health system certified by ForwardHealth to administer the Care4Kids program. Children's Hospital of Wisconsin will be responsible for providing or arranging for the provision of all services covered under Medicaid, with a small number of exceptions. The services not included in the Care4Kids program will be reimbursed as fee-for-service benefits. Children's Hospital of Wisconsin's integrated network of health care providers, which includes specialty and primary care physicians and clinics within the Children's Hospital System as well as providers who are participating in CCHP (Children's Community Health Plan), is intended to provide coordinated care and services to meet the individualized needs of each of the children enrolled across multiple disciplines, including physical, behavioral health, and dental care.

Care4Kids will be responsible for providing or arranging for the provision of all medically necessary services covered by Wisconsin Medicaid to enrollees. Providers are required to be part of the CCHP network to get reimbursed by Care4Kids. Providers interested in being a part of the network should contact CCHP. Out-of-network providers are required to call Care4Kids prior to providing services to a Care4Kids enrollee. In situations where emergency medical services are needed, out-of-network providers are required to contact Care4Kids within 24 hours of providing services.

Member Enrollment Verification

Providers should verify a member's enrollment before providing services to determine if the member is enrolled in Care4Kids. Members enrolled in Care4Kids will present a ForwardHealth member identification card.

Providers verifying enrollment on the ForwardHealth Portal will see Care4Kids under the MC Program heading in the Managed Care Enrollment panel.

For 271 response transactions, Care4Kids enrollment will be identified in the EB segment of the 2110C loop. Identified by "MC" in the EB01, "HM" in the EB04, and "Care4Kids" in the EB05. The MC provider contact information will be reported in the NM1 (name info), N3 (address info), and PER (telephone numbers) segments within the 2120C loop.

The WiCall AVR (automated voice response) system will identify Care4Kids as the state-contracted managed care program in which the member is enrolled.

Contact Information

Providers can contact CCHP at (800) 482-8010 for the following:

- To become part of the CCHP network.
- For coverage policy and procedure information, including PA (prior authorization) and claim submission guidelines, if they are already a Care4Kids network provider.

Member Information

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Archive Date:05/01/2018

Member Information:Enrollment Categories

Topic #16677

BadgerCare Plus Benefit Plan Changes

Effective April 1, 2014, all members eligible for BadgerCare Plus were enrolled in the BadgerCare Plus Standard Plan. As a result of this change, the following benefit plans were discontinued:

- BadgerCare Plus Benchmark Plan.
- BadgerCare Plus Core Plan.
- BadgerCare Plus Basic Plan.

Members who are enrolled in the Benchmark Plan or the Core Plan who met new income limits for BadgerCare Plus eligibility were automatically transitioned into the BadgerCare Plus Standard Plan on April 1, 2014. In addition, the last day of BadgerRx Gold program coverage for all existing members was March 31, 2014.

Providers should refer to the March 2014 Online Handbook archive of the appropriate service area for policy information pertaining to these discontinued benefit plans.

Topic #3324

Eligibility Requirements

To be eligible for the TB-Only (Tuberculosis-Related Services-Only) Benefit, documentation must show that one of the following is true:

- The individual has evidence of latent TB infection.
- The individual has evidence of active TB disease.
- The individual has a negative tuberculin skin test, but a positive culture.
- The individual tests negative for TB but requires a TB-related drug and/or surgical therapy based on a physician's judgment.
- The individual requires testing to confirm the presence (or absence) of the TB organism based on a physician's judgment.

Individuals must also meet certain financial requirements. Individuals should contact their county/tribal social or human services agency or Medicaid outstation site for current financial requirements.

Topic #18777

Real-Time Eligibility Determinations

ForwardHealth may complete real-time eligibility determinations for BadgerCare Plus and/or Family Planning Only Services applicants who meet pre-screening criteria and whose reported information can be verified in real time while applying in ACCESS Apply for Benefits. Once an applicant is determined eligible through the real-time eligibility process, he or she is considered eligible for BadgerCare Plus and/or Family Planning Only Services and will be enrolled for 12 months, unless changes affecting eligibility occur before the 12-month period ends.

A member determined eligible through the real-time eligibility process will receive a temporary ID (identification) card for BadgerCare Plus and/or Family Planning Only Services. Each member will get his or her own card, and each card will include the

member's ForwardHealth ID number. The temporary ID card will be valid for the dates listed on the card and will allow the member to get immediate health care or pharmacy services.

Eligibility Verification

When a member is determined eligible for BadgerCare Plus and/or Family Planning Only Services through the real-time eligibility process, providers are able to see the member's eligibility information in Wisconsin's EVS (Enrollment Verification System) in real time. Providers should always verify eligibility through EVS prior to providing services.

On rare occasions, it may take up to 48 hours for eligibility information to be available through interChange. In such instances, if a member presents a valid temporary ID card, **the provider is still required to provide services**, even if eligibility cannot be verified through EVS.

Sample Temporary Identification Card for Badger Care Plus

To the Provider

The individual listed on this card has been enrolled in BadgerCare Plus. This card entitles the listed individual to receive health care services, including pharmacy services, through BadgerCare Plus from any Medicaid-enrolled provider. For additional information, call Provider Services at 800-947-9627 or refer to the ForwardHealth Online Handbook at *www.forwardhealth.wi.gov*.

NOTE:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services, as long as other reimbursement requirements are met. All policies regarding covered services apply for this individual, including the prohibition against billing members. If "Pending Assignment" is indicated after the name on this card, the member identification (ID) number will be assigned within one business day; the card is still valid. Refer to the ForwardHealth Online Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH SERVICES

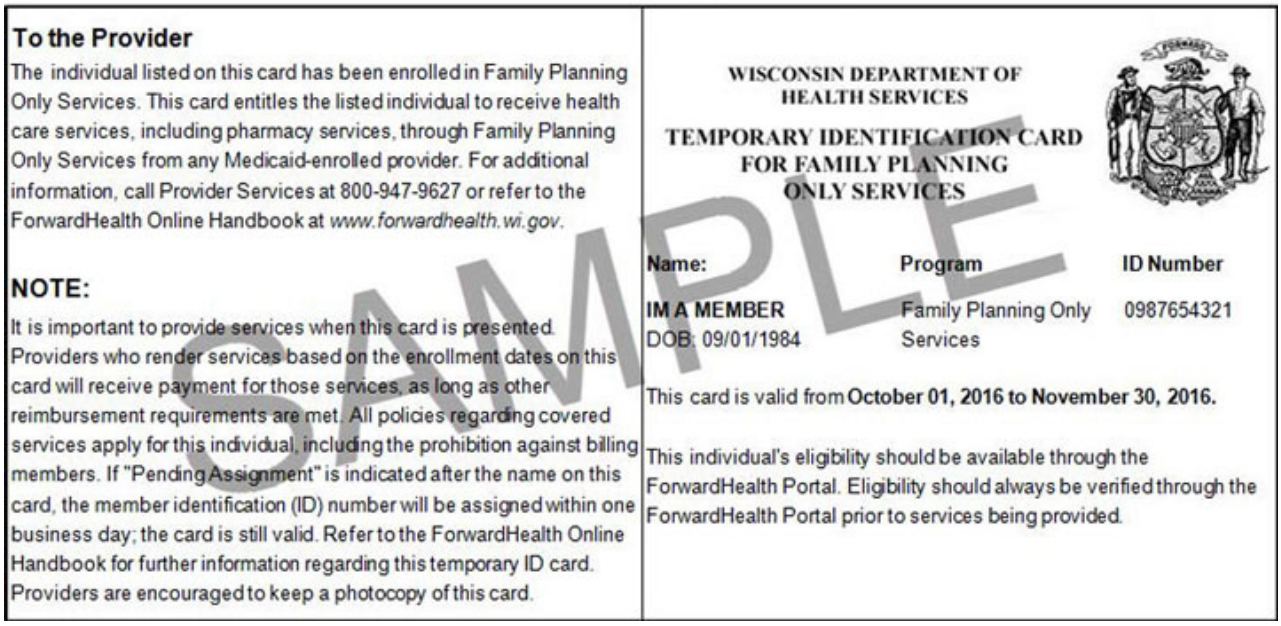
TEMPORARY IDENTIFICATION CARD FOR BADGERCARE PLUS

Name:	Program	ID Number
IM A MEMBER	BadgerCare Plus	0987654321
DOB: 09/01/1984		

This card is valid from **October 01, 2016 to November 30, 2016.**

This individual's eligibility should be available through the ForwardHealth Portal. Eligibility should always be verified through the ForwardHealth Portal prior to services being provided.

Sample Temporary Identification Card for Family Planning Only Services



To the Provider

The individual listed on this card has been enrolled in Family Planning Only Services. This card entitles the listed individual to receive health care services, including pharmacy services, through Family Planning Only Services from any Medicaid-enrolled provider. For additional information, call Provider Services at 800-947-9627 or refer to the ForwardHealth Online Handbook at *www.forwardhealth.wi.gov*.

NOTE:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services, as long as other reimbursement requirements are met. All policies regarding covered services apply for this individual, including the prohibition against billing members. If "Pending Assignment" is indicated after the name on this card, the member identification (ID) number will be assigned within one business day; the card is still valid. Refer to the ForwardHealth Online Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR FAMILY PLANNING ONLY SERVICES

SAMPLE

Name:	Program	ID Number
IM A MEMBER DOB: 09/01/1984	Family Planning Only Services	0987654321

This card is valid from **October 01, 2016 to November 30, 2016.**

This individual's eligibility should be available through the ForwardHealth Portal. Eligibility should always be verified through the ForwardHealth Portal prior to services being provided.

Topic #262

Tuberculosis-Related Services-Only Benefit

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

Identification Cards

Topic #324

ForwardHealth Cards

Most members, whether they have coverage for all services or limited services, receive a ForwardHealth card. Therefore, members of the TB-Only (Tuberculosis-Related Services-Only) Benefit receive a ForwardHealth card.

Special Enrollment Circumstances

Topic #304

Retroactive Eligibility

Some individuals may not be determined to have coverage for the TB-Only (Tuberculosis-Related Services-Only) Benefit until the TB infection or disease is clinically confirmed. These individuals may request that coverage for the TB-Only Benefit be retroactive to the date the infection or disease is confirmed.

Provider Enrollment and Ongoing Responsibilities

6

Archive Date:05/01/2018

Provider Enrollment and Ongoing Responsibilities:Documentation

Topic #16157

Policy Requirements for Use of Electronic Signatures on Electronic Health Records

For ForwardHealth policy areas where a signature is required, electronic signatures are acceptable as long as the signature meets the requirements. When ForwardHealth policy specifically states that a handwritten signature is required, an electronic signature will not be accepted. When ForwardHealth policy specifically states that a written signature is required, an electronic signature will be accepted.

Reimbursement for services paid to providers who do not meet all electronic signature requirements may be subject to recoupment.

Electronic Signature Definition

An electronic signature, as stated in s. 137.11(8), Wis. Stats., is "an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record."

Some examples include:

- Typed name (performer may type his or her complete name).
- Number (performer may type a number unique to him or her).
- Initials (performer may type initials unique to him or her).

All examples above must also meet all of the electronic signature requirements.

Benefits of Using Electronic Signatures

The use of electronic signatures will allow providers to:

- Save time by streamlining the document signing process.
- Reduce the costs of postage and mailing materials.
- Maintain the integrity of the data submitted.
- Increase security to aid in non-repudiation.

Electronic Signature Requirements

By following the general electronic signature requirements below, the use of electronic signatures provides a secure alternative to written signatures. These requirements align with HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule guidelines.

General Requirements

When using an electronic signature, all of the following requirements must be met:

- The electronic signature must be under the sole control of the rendering provider. Only the rendering provider or designee has the authority to use the rendering provider's electronic signature. Providers are required to maintain documentation that shows the electronic signature that belongs to each rendering provider if a numbering or initial system is used (e.g., what number is assigned to a specific rendering provider). This documentation must be kept confidential.
- The provider is required to have current policies and procedures regarding the use of electronic signatures. The DHS (Department of Health Services) recommends the provider conduct an annual review of policies and procedures with those using electronic signatures to promote ongoing compliance and to address any changes in the policies and procedures.
- The provider is required to conduct or review a security risk analysis in accordance with the requirements under 45 CFR s. 164.308(a)(1).
- The provider is required to implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
- The provider is required to establish administrative, technical, and physical safeguards in compliance with the HIPAA Security Rule.

Electronic Health Record Signature Requirements

An EHR (electronic health record) that utilizes electronic signatures must meet the following requirements:

- The certification and standard criteria defined in the Health Information Technology Initial Set of Standards, Implementation Specifications, Certification Criteria for Electronic Health Record Technology Final Rule (45 CFR Part 170) and any revisions including, but not limited to, the following:
    - Assign a unique name and/or number for identifying, tracking user identity, and establishing controls that permit only authorized users to access electronic health information.
    - Record actions related to electronic health information according to the standard set forth in 45 CFR s. 170.210.
    - Enable a user to generate an audit log for a specific time period. The audit log must also have the ability to sort entries according to any of the elements specified in the standard 45 CFR s. 170.210.
    - Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.
    - Record the date, time, patient identification, and user identification when electronic health information is created, modified, accessed, or deleted. An indication of which action(s) occurred and by whom must also be recorded.
    - Use a hashing algorithm with a security strength equal to or greater than SHA-1 (Secure Hash Algorithm 1) as specified by the NIST (National Institute of Standards and Technology) in FIPS PUB 180-3 (October 2008) to verify that electronic health information has not been altered. (Providers unsure whether or not they meet this guideline should contact their IT (Information Technology) and/or security/privacy analyst.)
- Ensure the EHR provides:
    - Nonrepudiation — assurance that the signer cannot deny signing the document in the future.
    - User authentication — verification of the signer's identity at the time the signature was generated.
    - Integrity of electronically signed documents — retention of data so that each record can be authenticated and attributed to the signer.
    - Message integrity — certainty that the document has not been altered since it was signed.
    - Capability to convert electronic documents to paper copy — the paper copy must indicate the name of the individual who electronically signed the form as well as the date electronically signed.
- Ensure electronically signed records created by the EHR have the same back-up and record retention requirements as paper records.

Ongoing Responsibilities

Topic #15157

Recovery Audit Contractor Audits

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

Note: The RAC will not audit claims submitted for Family Planning Only Services, SeniorCare, WCDP (Wisconsin Chronic Disease Program), the WWWP (Wisconsin Well Woman Program), and ADAP (Wisconsin AIDS Drug Assistance Program).

The overall goal of the RAC program is to identify and decrease improper payments. The audits will ensure that payments are for services covered under the programs in which the member was enrolled and that the services were actually provided and properly billed and documented. The audits are being conducted under Generally Accepted Government Auditing Standards.

Providers will be selected for audits based on data analysis by the RAC and referrals by state agencies. The RAC will ensure that its audits neither duplicate state audits of the same providers nor interfere with potential law enforcement investigations.

Providers who receive a notification regarding an audit should follow the instructions as outlined in the notification within the requested time frames.

Affected Providers

Any provider may be audited, including, but not limited to, fee-for-service providers, institutional and non-institutional providers, as well as managed care entities.

Additional Information

Any questions regarding the RAC program should be directed to HMS at (800) 310-0865. Refer to the RAC Web site for additional information regarding HMS RAC activities.

Provider Enrollment

Topic #284

Separate Enrollment Not Required

Medicaid-enrolled providers may provide TB (tuberculosis)-related services to members of the TB-Only (Tuberculosis-Related Services-Only) Benefit. No separate enrollment is required to provide these services.

ForwardHealth has determined which Medicaid-enrolled providers may provide certain services and receive reimbursement through the TB-Only Benefit.

Provider Numbers

Topic #5096

Taxonomy Codes

Taxonomy codes are standard code sets used to provide information about provider type and specialty for the provider's enrollment. ForwardHealth uses taxonomy codes as additional data for correctly matching the NPI (National Provider Identifier) to the provider file.

Providers are required to use a taxonomy code when the NPI reported to ForwardHealth corresponds to multiple enrollments and the provider's practice location ZIP+4 code does not uniquely identify the provider.

Providers are allowed to report multiple taxonomy codes to ForwardHealth as long as the codes accurately describe the provider type and specialty for the provider's enrollment. When doing business with ForwardHealth, providers may use any one of the reported codes. Providers who report multiple taxonomy codes will be required to designate one of the codes as the primary taxonomy code; ForwardHealth will use this primary code for identification purposes.

Providers who wish to change their taxonomy code or add additional taxonomy codes may do so using the demographic maintenance tool. Most taxonomy code changes entered through the demographic maintenance tool will take effect in real time; providers may use the new codes immediately on transactions.

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

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

Topic #5097

ZIP Code

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

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

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

Reimbursement

7

Archive Date:05/01/2018

Reimbursement:Copayment

Topic #261

Prohibited

Providers are prohibited from collecting copayment from members of the TB-Only (Tuberculosis-Related Services-Only) Benefit when providing DOT (directly observed therapy), TB (tuberculosis) symptom and treatment monitoring, or patient education and anticipatory guidance. For information about charging copayment for other services, the information pertaining to the provider's primary service area must be referenced.

Resources

8

Archive Date:05/01/2018

Resources:Portal

Topic #5157

Cost Share Reports for Long-Term Managed Care Organizations

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

Topic #5158

Managed Care Organization Portal Reports

The following reports are generated to MCOs (managed care organizations) through their account on the ForwardHealth MCO Portal:

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

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

Capitation Payment Listing Report

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

Initial Enrollment Roster Report

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

Final Enrollment Roster Report

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

Other Reports

Additional reports are available for BadgerCare Plus HMOs, SSI HMOs, and long-term MCOs. Some are available via the

Portal and some in the secure FTP (file transfer protocol).

Topic #5089

Other Business Enhancements Available on the Portal

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

- Verify member enrollment.
- View RAs (Remittance Advice).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice).
- Update and maintain provider file information. Providers have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT (electronic funds transfer).
- Track provider-submitted PA (prior authorization) requests.

Training Opportunities

Topic #12757

Training Opportunities

The Provider Relations representatives conduct training sessions in a variety of formats on both program-specific and topic-specific subjects. There is no fee for attending/accessing these training sessions.

On-Site Sessions

On-site training sessions are offered at various locations (e.g., hotel conference rooms, provider facilities) throughout the state. These training sessions include general all-provider sessions, service-specific and/or topic-specific sessions, and program-specific (such as WCDP (Wisconsin Chronic Disease Program) or the WWWP (Wisconsin Well Woman Program)) sessions.

Registration is required to attend on-site sessions. Online registration is available on the Trainings page of the Providers area of the Portal.

Online (Real-Time, Web-Based) Sessions

Online (real-time, web-based) training sessions are available and are facilitated through HPE® MyRoom. MyRoom sessions are offered on many of the same topics as on-site sessions, but online sessions offer the following advantages:

- Participants can attend training at their own computers without leaving the office.
- Sessions are interactive as participants can ask questions during the session.
- If requested or needed, a session can be quickly organized to cover a specific topic for a small group or office.

For some larger training topics (such as ForwardHealth Portal Fundamentals), the training may be divided into individual modules, with each module focused on a particular subject. This allows participants to customize their training experience.

Registration, including an e-mail address, is required to attend Virtual Room sessions, so important session information can be sent to participants prior to the start of the session. Online registration is available on the Trainings page of the Portal.

Recorded Webcasts

Recorded Webcasts are available on a variety of topics, including some of the same topics as on-site and online sessions. Like Virtual Room sessions, some recorded Webcasts on larger training topics may be divided into individual Webcast modules, allowing participants to customize their training experience. Recorded Webcasts allow providers to view the training at their convenience on their own computers.

Registration is not required to view a recorded Webcast. Related training materials are available to download and print from the specific Webcast training session page on the Portal.

Notification of Training Opportunities

In addition to information on the Trainings page of the Portal, upcoming training session information is distributed directly through messages to providers who have secure Portal accounts and to providers who have registered for the ForwardHealth e-mail subscription service.

To sign up for a secure Portal account, click the "Request Portal Access" link in the Quick Links box on the Provider page of the Portal. To sign up for e-mail subscription, click "Register for E-mail Subscription" in the Quick Links box on the Provider page of the Portal.