Certification and Ongoing Responsibilities

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Certification and Ongoing Responsibilities:Certification

Separate Certification Not Required

Medicaid-certified providers may provide TB-related services to members of the TB-Only Benefit. No separate certification is required to provide these services.

BadgerCare Plus has determined which Medicaid-certified providers may provide certain services and receive reimbursement through the TB-Only Benefit.

Provider Numbers

Taxonomy Codes

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

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

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

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

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

ZIP Code

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

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

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

Claims

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Claims:Submission

Reimbursement Reduction for Most Paper Claims

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

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

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

The reimbursement reduction applies to the following paper claims:

- 1500 Health Insurance Claim Form.
- UB-04 (CMS 1450) Claim Form.
- Compound Drug Claim Form.
- Noncompound Drug Claim Form.

Exceptions to Paper Claim Reimbursement Reduction

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

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

Submitting Claims

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

Covered and Noncovered Services

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Covered and Noncovered Services:Codes

Diagnosis Codes

With the exception of independent laboratory providers, portable X-ray providers, and pharmacy providers, providers should indicate a TB-related ICD-9-CM 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 Benefit. 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.

Diagnosis Codes	Descriptions
010.0x-018.9x	Primary tuberculosis (TB) infection Pulmonary TB Other respiratory TB Tuberculosis of meninges and central nervous system Tuberculosis of intestines, peritoneum, and mesenteric glands Tuberculosis of bones and joints Tuberculosis of genitourinary system Tuberculosis of other organs Military TB
137.0-137.4	Late effects of TB
771.2	Infections specific to the perinatal period; other congenital infections; congenital TB
795.5	Nonspecific abnormal histological and immunological findings; nonspecific reaction to tuberculin skin test without active TB
V01.1	Contact with or exposure to communicable diseases; TB
V12.01	Personal history of certain other diseases; infectious and parasitic diseases; TB
V71.2	Observation and evaluation for suspected conditions not found; observation for suspected TB
V72.5	Special investigations and examinations; radiological examination, not elsewhere classified
V74.1	Special screening examination for bacterial and spirochetal diseases; pulmonary TB

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

Place of Service Codes

Services that are reimbursable through the TB-Only Benefit must be provided in an allowable POS.

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
20	Urgent Care Facility
22	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

Procedure Codes

Wisconsin Medicaid has identified commonly used allowable procedure codes for services provided to members receiving the TB-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. • HealthCheck screeners. • Home health agencies. • Nurse midwives. • Nurse practitioners. • Physician assistants. • Physician clinics. • Physicians. • PNCC 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	
71010	Radiologic examination, chest; single view, frontal	• Family planning clinics. • FQHCs. • HealthCheck screeners. • Nurse midwives. • Nurse practitioners. • Outpatient hospitals. • Physician assistants. • Physician clinics. • Physicians. • Portable X-ray providers. • PNCC providers.
71020	Radiologic examination, chest, two views, frontal and lateral	

86480	Tuberculosis test, cell mediated immunity measurement of gamma interferon antigen response	• 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.
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device (94664 can be reported one time only per day of service)	• FQHCs. • HealthCheck screeners. • Nurse midwives. • Nurse practitioners. • Outpatient hospitals. • Physician assistants. • Physician clinics. • Physicians. • PNCC providers.

99000	Handling and/or conveyance of specimen for transfer from the physician's 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.

Unlisted Procedure Codes

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

Before considering using an unlisted, or NOC, procedure code, a provider should determine if there is another more specific code that could be indicated to describe the procedure or service being performed/provided. If there is no more specific code available, the provider is required to submit the appropriate documentation, which could include a PA request, to justify use of the unlisted procedure code and to describe the procedure or service rendered. Submitting the proper documentation, which could include a PA request, may result in more timely claims processing.

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

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

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

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

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

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

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

For most situations, once the provider has an approved PA request for the unlisted procedure code, there is no need to submit

additional documentation along with the claim.

Unlisted Codes That Do Not Require Prior Authorization

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

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

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

How to Submit Claims and Related Documentation

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

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

Covered Services and Requirements

A Comprehensive Overview

Members of the TB-Only Benefit are enrolled *only* for covered TB-related outpatient services. These services include:

- Drugs.
- Physician services.
- Laboratory services.
- Radiology services.
- Case management services.
- Transportation services.
- DOT.
- 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.

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 Benefit.

Allowable Providers

Medicaid case management services providers may provide TB-related case management services and receive reimbursement through the TB-Only Benefit. In addition, providers must be Medicaid-certified for the target group "individuals infected with TB." Target populations may be added by submitting the Case Management Target Population Change Request form.

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.

Directly Observed Therapy

Full-benefit Medicaid members and members of the TB-Only Benefit are eligible for DOT. 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 medication as prescribed in his or her treatment plan.

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

Providers are required to indicate procedure code H0033 (Oral medication administration, direct observation [one unit is 15 minutes]) on claims for DOT services for members receiving TB treatment. This procedure code is only allowable for providers who observe the ingestion of TB medications for members receiving TB treatment.

A valid TB-related diagnosis must be indicated on claims billing procedure code H0033.

Allowable Providers

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

Drugs

TB-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 Benefit.

Allowable Providers

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

Laboratory Services

TB-related laboratory services, including services to diagnose or confirm the presence of TB infection or disease, may be reimbursed through the TB-Only Benefit.

Allowable Providers

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

Patient Education and Anticipatory Guidance

Full-benefit Medicaid members and members receiving the TB-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 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.

Allowable Providers

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

Physician Services

TB-related physician services, including office visits, may be reimbursed through the TB-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.

Radiology Services

TB-related radiology services may be reimbursed through the TB-Only Benefit.

Allowable Providers

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

Resetting Service Limitations

Service limitations used by a member enrolled in the BadgerCare Plus Benchmark Plan and the BadgerCare Plus Core Plan within their continuous 12-month enrollment year will reset in the following situations:

- A fee-for-service member is enrolled in an HMO.
- A member switches from one HMO to another HMO (only allowable within the first 90 days of Core Plan enrollment).
- A member is disenrolled from an HMO and moves to fee-for-service.

Note: When a member goes from fee-for-service into an HMO and subsequently moves back to fee-for-service, service limitations will not be reset for the services that were received under the initial fee-for-service enrollment period.

PA requests for services beyond the covered service limitations will be denied.

Resetting service limitations does not change a member's Benchmark Plan enrollment year or a member's Core Plan enrollment year.

Symptom and Treatment Monitoring

Full-benefit Medicaid members and members receiving the TB-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 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 when submitting claims for TB symptom and treatment monitoring:

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

Allowable Providers

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

Transportation Services

Transportation to receive TB-related services is covered for members receiving the TB-Only Benefit. The member or the member's case manager should contact the local county or tribal agency to arrange common carrier transportation.

Members who cannot travel safely by common carrier transportation may be eligible for transportation by SMV if they meet SMV criteria. TB infection or disease alone does not automatically qualify the member for transportation by SMV.

Noncovered Services

Noncovered Services

Inpatient hospital services and nursing home services are not covered through the TB-Only Benefit.

In addition, services not related to the treatment or complications of TB 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.

Member Information

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Member Information:Enrollment Categories

Eligibility Requirements

To be eligible for the TB-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.

Tuberculosis-Related Services-Only Benefit

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

Identification Cards

ForwardHealth Cards

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

Special Enrollment Circumstances

Retroactive Eligibility

Some individuals may not be determined to have coverage for the TB-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.

Reimbursement

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Reimbursement:Copayment

Prohibited

Providers are prohibited from collecting copayment from recipients of the TB-Only Benefit when providing DOT, TB 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

6

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Resources:Portal

ASC X12 Version 5010 and NCPDP Version D.0 Implementation Page

ForwardHealth has established a page on the ForwardHealth Portal designed to keep providers and trading partners informed of important dates and information related to the implementation of the new HIPAA ASC X12 version 5010 and NCPDP telecommunication standard version D.0. Providers, trading partners, partners, MCOs, and other interested parties are encouraged to check the 5010 page of the Portal often, as ForwardHealth will post new information regularly.

As information becomes available, ForwardHealth plans to include the following on the version 5010 and version D.0 page of the Portal:

- Questions and answers about the transition to the new standards.
- Companion documents for the new standards.
- External compliance testing schedule and procedures.
- Links to national resources for version 5010 and version D.0 transactions.
- An e-mail address to which providers and trading partners can send their questions (*forwardhealth5010support@wi.gov*).

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.

Managed Care Organization Portal Reports

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

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

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

Capitation Payment Listing Report

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

Initial Enrollment Roster Report

The Initial Enrollment Roster Report is generated according to the annual schedules detailing the number of new and continuing

members enrolled in the MCO and those disenrolled before the next enrollment month.

Final Enrollment Roster Report

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

Other Reports

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

Other Business Enhancements Available on the Portal

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

- Verify member enrollment.
- View RAs.
- Designate which trading partner is eligible to receive the provider's 835.
- Update and maintain provider file information. Providers have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT.
- Track provider-submitted PA requests.