Provider Enrollment and Ongoing Responsibilities

1

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Provider Enrollment and Ongoing Responsibilities:Provider Enrollment

Topic #3969

Categories of Enrollment

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

- Billing and rendering provider
- Rendering-only provider
- Billing-only provider (including group billing)

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

Billing and Rendering Provider

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

Rendering-Only Provider

A provider enrolled as a rendering-only provider who practices under the professional supervision of another provider. Rendering-only providers enrollment cannot submit claims to ForwardHealth directly. Instead, they have reimbursement rates established for their provider type. Claims for services provided by a rendering provider must include the supervising provider or group provider as the billing provider.

Billing-Only Provider (Including Group Billing)

Billing-only providers can submit claims to ForwardHealth while a separate rendering-only provider is required on those claims.

Group Billing

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

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

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

Topic #2790

Durable Medical Equipment and Disposable Medical Supplies

Medicaid-enrolled PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) providers do not need to separately enroll to dispense certain DME (durable medical equipment) and DMS (disposable medical supplies).

Topic #14137

Enrollment Requirements Due to the Affordable Care Act

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

- Providers are assigned a risk level of limited, moderate, or high. Most of the risk levels have been established by the federal CMS (Centers for Medicare & Medicaid Services) based on an assessment of potential fraud, waste, and abuse for each provider type.
- Providers are screened according to their assigned risk level. Screenings are conducted during enrollment, re-enrollment, and revalidation.
- Certain provider types are subject to an application fee. This fee has been federally mandated and may be adjusted annually. The fee is used to offset the cost of conducting screening activities.
- Providers are required to undergo revalidation every three years.
- All physicians and other professionals who prescribe, refer, or order services and other providers who receive Medicaid funds are required to be enrolled as a participating Medicaid provider.
- Payment suspensions are imposed on providers based on a credible allegation of fraud.
- Providers are required to submit personal information about all persons with an ownership or controlling interest, agents, and managing employees at the time of enrollment, re-enrollment, and revalidation.

Topic #194

In-State Emergency Providers and Out-of-State Providers

ForwardHealth requires all in-state emergency providers and out-of-state providers who render services to BadgerCare Plus, Medicaid, or SeniorCare members to be enrolled in Wisconsin Medicaid. Information is available regarding the enrollment options for in-state emergency providers and out-of-state providers.

In-state emergency providers and out-of-state providers who dispense covered outpatient drugs will be assigned a professional dispensing fee reimbursement rate of $10.51.

Topic #193

Materials for New Providers

On an ongoing basis, providers should refer to the Online Handbook for the most current BadgerCare Plus, Medicaid, and HDAP (Wisconsin HIV Drug Assistance Program) information. Future changes to policies and procedures are published in

ForwardHealth Updates.

Topic #2789

Overview of Enrollment and Reimbursement

	Enrollment Requirements	Reimbursement	Provider Numbers
Physical Therapists	Physical therapists may become Medicaid-enrolled if they are licensed under Wis. Stat. ch. 448 and Wis. Admin. Code ch. PT 1.	Wisconsin Medicaid directly reimburses physical therapists for covered PT (physical therapy) services when all program requirements are met.	Wisconsin Medicaid assigns physical therapists a billing rendering provider number. The billing rendering provider number can be used as a billing number and a rendering provider number. It allows physical therapists to do the following: - Request PA (prior authorization) and submit claims - Request PA and submit claims for the services of PTAs (physical therapist assistants), PT students, and PT aides who are supervised by the physical therapist
Physical Therapist Assistants	Physical therapist assistants may become Medicaid-enrolled if they are licensed under Wis. Stat. ch. 448 and Wis. Admin. Code ch. PT 5.	Wisconsin Medicaid does not directly reimburse PTAs. When all program requirements are met, covered PT services provided by PTAs may be reimbursed under the supervising therapist's, therapy clinic's, therapy group's, rehabilitation agency's, hospital's, or nursing home's billing number.	Wisconsin Medicaid assigns PTAs a non-billing rendering provider number. The non-billing rendering provider number can be used as a rendering provider number but not as a billing number. The non-billing provider number does not allow PTAs to request PA, submit claims, or receive reimbursement.
Physical Therapy Aides*	Wisconsin Medicaid does not enroll PT aides. A PT aide is an individual who provides delegated PT services	Wisconsin Medicaid does not directly reimburse PT aides. When all program requirements are met,	Wisconsin Medicaid does not assign a rendering provider number or a billing number to PT aides.

	and is trained in a manner appropriate to their job duties.	covered PT services delegated to and provided by PT aides may be reimbursed under either of the following: - The supervising therapist's, rehabilitation agency's, or hospital's (for outpatient services) billing number - The supervising therapist's rendering provider number **and** the therapy group's, therapy clinic's, hospital's (for off-site services), or nursing home's billing number	
Occupational Therapists	Occupational therapists may become Medicaid enrolled if they are licensed under Wis. Stat. ch. 448 and Wis. Admin. Code ch. OT 2.	Wisconsin Medicaid directly reimburses occupational therapists for covered OT (occupational therapy) services when all program requirements are met.	Wisconsin Medicaid assigns occupational therapists a billing rendering provider number. The billing rendering provider number can be used as a billing number and a rendering provider number. It allows occupational therapists to do the following: - Request PA and submit claims - Request PA and submit claims for the services of COTAs (certified occupational therapy assistants) and OT students who are supervised by the occupational therapist
Certified Occupational Therapy Assistants	Occupational therapy assistants may become Medicaid-enrolled if they are licensed under Wis. Stat. ch. 448 and Wis. Admin. Code ch. OT 2.	Wisconsin Medicaid does not directly reimburse COTAs. When all program requirements are met, covered OT services provided by COTAs may be reimbursed under the supervising therapist's, therapy clinic's, therapy	Wisconsin Medicaid assigns COTAs a non-billing rendering provider number. The non-billing rendering provider number can be used as a rendering

		group's, rehabilitation agency's, hospital's, or nursing home's billing provider number.	provider number but not as a billing number. The non-billing provider number does not allow COTAs to request PA, submit claims, or receive reimbursement.
Speech-Language Pathologists	Speech-language pathologists may become Medicaid-enrolled if they are licensed under Wis. Stat. ch. 459 and Wis. Admin. Code ch. HAS. School-based service speech-language pathologists may also become Medicaid-enrolled if any of the following are true: - They are certified by the ASHA (American Speech-Language-Hearing Association). - They have completed the education and work experience necessary for ASHA certification. - They have completed the education and are in the process of completing the work experience necessary for ASHA certification.	Wisconsin Medicaid directly reimburses speech-language pathologists for covered SLP (speech and language pathology) services when all program requirements are met.	Wisconsin Medicaid assigns speech-language pathologists a billing rendering provider number. The billing rendering provider number can be used as a billing number and a rendering provider number. It allows speech-language pathologists to do the following: - Request PA and submit claims - Request PA and submit claims for the services of SLP provider assistants and SLP students who are supervised by the speech-language pathologist
SLP Provider Assistants	Individuals with a Bachelor's degree (B.A. or B.S.) in SLP may become enrolled as a SLP non-billing rendering provider. SLP non-billing providers, also referred to as SLP provider assistants, are required to submit a copy of their degree transcript.	Wisconsin Medicaid does not directly reimburse SLP provider assistants. When all program requirements are met, covered SLP services provided by SLP provider assistants may be reimbursed under the supervising therapist's, speech and hearing clinic's, therapy group's, rehabilitation agency's, hospital's, or nursing home's billing number.	Wisconsin Medicaid assigns SLP provider assistants a non-billing rendering provider number. The non-billing rendering provider number can be used as a rendering provider number but not as a billing number. The non-billing provider number does not allow SLP provider assistants to request PA, submit claims, or receive reimbursement.
PT, OT, and	Wisconsin Medicaid does not enroll	Wisconsin Medicaid does not directly	Wisconsin Medicaid does not assign

SLP Students	PT, OT, and SLP students. A PT, OT, or SLP student is an individual who is providing services during a practicum.	reimburse PT, OT, or SLP students. When all program requirements are met, covered services provided by PT, OT, and SLP students may be reimbursed under either of the following: - The supervising therapist's, rehabilitation agency's, or hospital's (for outpatient services) billing number - The supervising therapist's rendering provider number **and** the therapy group's, therapy clinic's, speech and hearing clinic's, hospital's (for off-site services), or nursing home's billing number	a rendering provider number or a billing number to PT, OT, or SLP students.
Therapy Groups, Therapy Clinics, or Speech and Hearing Clinics	Therapy groups that provide two or more types of therapy (for example, PT and OT or PT, OT, and SLP) may become Medicaid-enrolled as a therapy group. Therapy clinics that provide one type of therapy (for example, PT or OT) may become Medicaid-enrolled as a therapy clinic. Speech and hearing clinics may become Medicaid-enrolled if they are accredited by the ASHA. Wisconsin Medicaid requires providers employed by, or under contract to, groups and clinics to be individually enrolled in Wisconsin Medicaid.	Wisconsin Medicaid directly reimburses groups or clinics for covered PT, OT, and SLP services when all program requirements are met.	Wisconsin Medicaid assigns groups and clinics a group billing number that requires individual rendering provider numbers. Wisconsin Medicaid assigns an individual rendering provider number to each Medicaid-enrolled provider within the group or clinic. The group billing number used with an individual rendering provider number allows groups or clinics to do the following: - Request PA and submit claims - Receive one reimbursement and one R/S (Remittance and Status) Report and 835 (835 Health Care Claim Payment/Advice) transaction

			for services performed by individual providers within the group or clinic
Rehabilitation Agencies	Rehabilitation agencies must be enrolled in Medicare to obtain Medicaid enrollment. Wisconsin Medicaid requires providers employed by, or under contract to, rehabilitation agencies to meet all Medicaid enrollment requirements, but does not require them to be individually enrolled in Wisconsin Medicaid. The rehabilitation agency is required to maintain records showing that its individual providers meet Medicaid requirements. Medicaid therapy group providers considering conversion to the Medicaid rehabilitation agency provider type should contact Provider Services at 800-947-9627 or 608-221-9883 for more information. For information about Medicare enrollment providers should contact the DQA (Division of Quality Assurance) at the following address: Division of Quality Assurance PO Box 2969 Madison WI 53701-2969	Wisconsin Medicaid directly reimburses rehabilitation agencies for covered PT, OT, and SLP services when all program requirements are met.	Wisconsin Medicaid assigns rehabilitation agencies a group billing number that does **not** require a separate rendering provider number. Wisconsin Medicaid does not assign an individual rendering provider number to each provider within the rehabilitation agency. The group billing number can be used as a billing number and a rendering provider number. It allows rehabilitation agencies to do the following: - Request PA and submit claims - Receive one reimbursement and one R/S Report and 835 transaction for services performed by individual providers within the agency

*Medicaid reimbursement is not available for services provided by OT or SLP aides.

Topic #4457

Provider Addresses

ForwardHealth has the capability to store the following types of addresses and contact information:

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

Providers may submit additional address information or modify their current information using the demographic maintenance tool.

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

Topic #14157

Provider Enrollment Information Home Page

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

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

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

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

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

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

Topic #1931

Provider Type and Specialty Changes

Provider Type

Providers who want to add a provider type or change their current provider type are required to complete a new enrollment application for each provider type they want to add or change to because they need to meet the enrollment criteria for each provider type.

Provider Specialty

Providers who have the option to add or change a provider specialty can do so using the demographic maintenance tool. After adding or changing a specialty, providers may be required to submit documentation to ForwardHealth, either by uploading through the demographic maintenance tool or by mail, supporting the addition or change.

Providers should contact Provider Services with any questions about adding or changing a specialty.

Topic #22257

Providers Have 35 Days to Report a Change in Ownership

Medicaid-enrolled providers are required to notify ForwardHealth of a change in ownership within 35 calendar days after the effective date of the change, in accordance with the Centers for Medicare & Medicaid Services Final Rule 42 C.F.R. § 455.104 (c)(1)(iv).

Failure to report a change in ownership within 35 calendar days may result in denial of payment, per 42 C.F.R. § 455.104(e).

Note: For demographic changes that do not constitute a change in ownership, providers should update their current information using the demographic maintenance tool.

Written Notification and a New Enrollment Application Are Required

Any time a change in ownership occurs, providers are required to do **one** of the following:

- Mail a change in ownership notification to ForwardHealth. After mailing the notification, providers are required to complete a new Medicaid provider enrollment application on the Portal.
- Upload a change in ownership notification as an attachment when completing a new Medicaid provider enrollment application on the Portal.

ForwardHealth must receive the change in ownership notification, which must include the affected provider number (NPI (National Provider Identifier) or provider ID), within 35 calendar days **after** the effective date of the change in ownership.

Providers will receive written notification of their new Medicaid enrollment effective date in the mail once their provider file is updated with the change in ownership.

Special Requirements for Specific Provider Types

The following provider types require Medicare enrollment and/or Wisconsin DQA (Division of Quality Assurance) certification with current provider information before submitting a Medicaid enrollment change in ownership:

- Ambulatory surgery centers
- CHCs (Community Health Centers)
- ESRD (End Stage Renal Disease) services providers
- Home health agencies
- Hospice providers
- Hospitals (inpatient and outpatient)
- Nursing homes
- Outpatient rehabilitation facilities
- Rehabilitation agencies
- RHCs (Rural Health Clinics)
- Tribal FQHCs (Federally Qualified Health Centers)

Events That ForwardHealth Considers a Change in Ownership

ForwardHealth defines a change in ownership as an event where a different party purchases (buys out) or otherwise obtains ownership or effective control over a practice or facility.

The following events are considered a change in ownership and require the completion of a new provider enrollment application:

- Change from one type of business structure to another type of business structure. Business structures include the following:
  - Sole proprietorships
  - Corporations
  - Partnerships
  - Limited Liability Companies
- Change of name and TIN (Tax Identification Number) associated with the provider's submitted enrollment application (for example, EIN (Employer Identification Number))
- Change (addition or removal) of names identified as owners of the provider

Examples of a Change in Ownership

Examples of a change in ownership include 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.

End Date of Previous Owner's Enrollment

The end date of the previous owner's enrollment will be one day prior to the effective date for the change in ownership. When the Wisconsin DHS (Department of Health Services) is notified of a change in ownership, the original owner's enrollment will automatically be end-dated.

Repayment Following a Change in Ownership

Medicaid-enrolled providers who sell or otherwise transfer their business or business assets are required to repay ForwardHealth for any erroneous payments or overpayments made to them. If the previous owner does not repay ForwardHealth for any erroneous payments or overpayments, the new owner's application will be denied.

If necessary, ForwardHealth will hold responsible for repayment the provider to whom a transfer of ownership is made prior to

the final transfer of ownership. The provider acquiring the business is responsible for contacting ForwardHealth to ascertain if they are liable under this provision.

The provider acquiring the business is responsible for full repayment within 30 days after receiving such a notice from ForwardHealth.

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

Office of the Inspector General
PO Box 309
Madison WI 53701-0309

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

Automatic Recoupment Following a Change in Ownership

ForwardHealth will automatically recover payments made to providers whose enrollment has ended in the ForwardHealth system due to a change in ownership. This automatic recoupment for previous owners occurs about 45 days after DHS is notified of the change in ownership. The recoupment will apply to all claims processed with DOS (Dates of Service) after the provider's new end date.

New Prior Authorization Requests Must Be Submitted After a Change in Ownership

Medicaid-enrolled providers are required to submit new PA (Prior Authorization) requests when there is a change in billing providers. New PA requests must be submitted with the new billing provider's name and billing provider number. The expiration date of the new PA request will remain the same as the original PA request.

The provider is required to send the following to ForwardHealth with the new PA request:

- A copy of the original PA request, if possible
- The new PA request, including the required attachments and supporting documentation indicating the new billing provider's name, address, and billing provider number
- A letter requesting to enddate the original PA request (may be a photocopy), which should include the following information:
  - The previous billing provider's name and billing provider number, if known
  - The new billing provider's name and billing provider number
  - The reason for the change of billing provider (The new billing provider may want to verify with the member that the services from the previous billing provider have ended. The new billing provider may include this verification in the letter).
  - The requested effective date of the change

Submitting Claims After a Change in Ownership

The provider acquiring the business may submit claims with DOS on and after the change in ownership effective date.

Additional information on submission of timely filing requests or adjustment reconsideration requests is available.

How to Bill for a Hospital Stay That Spans a Change in Ownership

When a change in hospital ownership occurs, use the NPI that is current on the date of discharge. For example: A change in ownership occurs on July 1. A patient stay has DOS from June 26 to July 2. The hospital submits the claim using the NPI effective July 1.

How to Bill for a Nursing Home Stay That Spans a Change in Ownership

When a change in nursing home ownership occurs, use the NPI that is current on the date of discharge. For example: A change in ownership occurs on July 1. A nursing home patient stay has DOS from June 26 to July 2. The nursing home submits the claim using the NPI effective July 1.

For Further Questions

Providers with questions about changes in ownership may call Provider Services.

Topic #2788

Requirements

Physical therapists, PTAs (physical therapist assistants), occupational therapists, COTAs (certified occupational therapy assistants), and speech-language pathologists offering services addressed in this handbook are required to be licensed through the Wisconsin DSPS (Department of Safety and Professional Services). Temporary licensure through the DSPS is sufficient but is subject to the terms of the DSPS. Program requirements may not be construed to supersede the provisions for registration or licensure under Wis. Stats. §§ 448 or 459.24.

Physical therapists, PTAs, occupational therapists, COTAs, and speech-language pathologists who are granted border status are exempt from the Wisconsin licensure requirement. However, these providers are required to be licensed by the appropriate agency in the state they practice. Wis. Admin. Code § DHS 105.48 contains more information about border status.

Wisconsin Medicaid requires providers offering **outpatient** hospital PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services who are employed by, or under contract to, hospitals to meet all Medicaid enrollment requirements but does not require them to be individually enrolled with Wisconsin Medicaid. The hospital is required to maintain records showing that its individual providers meet Medicaid requirements.

Wisconsin Medicaid requires providers offering **off-site** hospital PT, OT, and SLP services who are employed by, or under contract to, hospitals to be individually enrolled with Wisconsin Medicaid.

Wisconsin Medicaid requires PT, OT, and SLP providers employed by, or under contract to, nursing homes to be individually enrolled with Wisconsin Medicaid.

Topic #2787

Supervision Requirements

When supervision requirements are met, Medicaid reimbursement is available for services provided by assistants, students, or aides who are qualified to provide the service. Refer to the following table for allowable services and supervision requirements for PTAs (physical therapist assistants), COTAs (certified occupational therapy assistants), SLP (speech and language pathology) provider assistants, PT (physical therapy) students, OT (occupational therapy) students, SLP students, and PT aides. The following definitions apply to the supervision requirements:

- "Direct, immediate, on-premises supervision" is defined as face-to-face contact between the supervisor and the person

being supervised, as necessary, with the supervisor being physically present in the same building when the service is being performed by the person being supervised.

- General supervision is defined as direct, on-premises contact between the supervisor, the person being supervised, and the member at least once every two weeks. Between direct contacts, the supervisor is required to maintain indirect, off-premises contact (by telephone, written reports, and group conferences) with the person being supervised.
- Direct, immediate, one-to-one supervision is defined as one-to-one supervision with face-to-face contact between the person being supervised and the supervisor during each PT, OT, or SLP session with the person being supervised assisting the supervisor.

	Allowable Services	Supervision Requirements
PTAs	Certain PT services, such as evaluations, may not be reimbursed by Wisconsin Medicaid when provided by PTAs.	PTAs must be under the direct, immediate, on-premises supervision of a Medicaid-enrolled physical therapist who is responsible for member care. However, if a supervision waiver is obtained, PTAs may provide services under the general supervision of a Medicaid-enrolled physical therapist.
COTAs	Certain OT services, such as evaluations, may not be reimbursed by Wisconsin Medicaid when provided by COTAs.	For some services (activities of daily living skills), COTAs are required to be under the general supervision of a Medicaid-enrolled occupational therapist who is responsible for member care. The following circumstances must apply: - The COTA is providing services that are for the purpose of providing activities of daily living skills. - The supervising therapist visits the member on a biweekly basis or after every five contacts between the COTA and the member, whichever is greater. - The COTA and supervising therapist meet to discuss treatment of the member after every five contacts between the COTA and the member. For all other services, COTAs must be under the direct, immediate, on-premises supervision of a Medicaid-enrolled occupational therapist who is responsible for member care. However, if a supervision waiver is obtained, COTAs may provide these services under general supervision.
SLP Provider Assistants	Evaluations (92521–92524, 92597, 92607, 92608, and 92610) may not be reimbursed by Wisconsin Medicaid when provided by SLP provider assistants. All other SLP services may be reimbursed by Wisconsin Medicaid when	SLP provider assistants are required to be under the direct, immediate, on-premises supervision of an ASHA (American Speech-Language-Hearing Association)-certified and Medicaid-enrolled supervisor who is

	provided by SLP provider assistants.	responsible and liable for performance of services delivered in accordance with Wis. Admin. Code § DHS 107.18(1)(a).
PT, OT, and SLP Students	All PT, OT, and SLP services, including evaluations, may be reimbursed by Wisconsin Medicaid when provided by students during their practicum.	PT and OT students must be under the direct, immediate, on-premises supervision of a Medicaid-enrolled physical therapist or occupational therapist who is responsible for member care. SLP students must be under the direct, immediate, on-premises supervision of an ASHA-certified and Medicaid-enrolled speech and language pathologist who is responsible for member care.
PT Aides	The following PT services may be reimbursed by Wisconsin Medicaid when provided by PT aides who are trained in a manner appropriate to their job duties: - Assisting with the use of equipment and performing simple modalities once the member's program has been established, and the member's response to the equipment is highly predictable. - Performing simple activities required to assist in the performance or conclusion of treatment (such as transferring a member to or from a mat). - Providing protective assistance during exercise, activities of daily living skills, and ambulation activities related to the development of strength and refinement of activity. Clinical services that exceed a PT aide's competence, education, training, and experience are not reimbursable by Wisconsin Medicaid.	PT aides must be under the direct, immediate, one-to-one supervision of a Medicaid-enrolled physical therapist who is responsible for member care. The therapist-to-aide ratio must be 1:1, except as noted. Wisconsin Medicaid may exempt a facility from this supervision requirement if it determines that direct, immediate, one-to-one supervision is not required for specific assignments that PT aides are performing. For example, facilities providing significant amounts of hydrotherapy may be eligible for a supervision exemption for PT aides who fill or clean tubs. If an exemption is granted, Wisconsin Medicaid will indicate the specific services for which the exemption is granted and set an appropriate supervision ratio for these services.

Topic #2786

Supervision Waiver

Physical therapists and occupational therapists who wish to use assistants under general supervision may receive a waiver granting an alternative to BadgerCare Plus' current supervision requirements for PTAs and COTAs. The waiver must be requested when a provider wishes to use assistants under general supervision as allowed by the supervision requirements of the Wisconsin DSPS (Department of Safety and Professional Services). Each billing provider should complete the Request for Waiver of Physical Therapist Assistant and Occupational Therapy Assistant Supervision Requirements (F-01149 (07/2012)) form only once. Providers should retain copies of these forms for enrollment and audit purposes.

The waiver is automatically granted when BadgerCare Plus acknowledges receipt of the form and is effective until the direct, immediate, on-premises supervision requirement is revised through a change to Wisconsin Administrative Code.

Topic #2791

Declaration of Supervision

PTAs and COTAs are required to complete the Declaration of Supervision for Nonbilling Providers (F-01182 (06/2025)) form for changes in physical address or supervising therapist.

SLP provider assistants are required to notify Wisconsin Medicaid immediately using the demographic maintenance tool when they have a change in supervisor, employer, or work address.

Topic #14317

Terminology to Know for Provider Enrollment

ForwardHealth adopted terminology due to the ACA (Affordable Care Act), which is included in the following table. This terminology is useful to providers during the provider enrollment and revalidation processes. Providers may refer to the Medicaid rule 42 C.F.R. § s. 455.101 for more information.

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

Person with an ownership or control interest	A person or corporation for which one or more of the following applies: • Has an ownership interest totaling 5% or more in a disclosing entity • Has an indirect ownership interest equal to 5% or more in a disclosing entity • Has a combination of direct and indirect ownership interest equal to 5% or more in a disclosing entity • Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or asset of the disclosing entity • Is an officer or director of a disclosing entity that is organized as a corporation • Is a person in a disclosing entity that is organized as a partnership
Subcontractor	• An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or, • An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.
Re-enrollment	Re-enrollment of a provider whose Medicaid enrollment has ended for any reason other than sanctions or failure to revalidate may be re-enrolled as long as all licensure and enrollment requirements are met. Providers should note that when they re-enroll, application fees and screening activities may apply. Re-enrollment was formerly known as re-instate.
Revalidation	All enrolled providers are required to revalidate their enrollment information every three years to continue their participation with Wisconsin Medicaid. Revalidation was formerly known as recertification.

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

Ongoing Responsibilities

Topic #220

Accommodating Members With Disabilities

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

Topic #219

Civil Rights Compliance (Nondiscrimination)

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

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

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

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

- Denial of aid, care, services, or other benefits
- Segregation or separate treatment
- Restriction in any way of any advantage or privilege received by others (There are some program restrictions based on eligibility classifications.)
- Treatment different from that given to others in the determination of eligibility
- Refusing to provide an oral language interpreter to persons who are considered LEP (limited English proficient) at no cost to the LEP individual in order to provide meaningful access
- Not providing translation of vital documents to the LEP groups who represent 5% or 1,000, whichever is smaller, in the provider's area of service delivery

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

Providers are required to be in compliance with the previously mentioned laws as they are currently in effect or amended. Providers who employ 25 or more employees and receive $25,000 or more annually in Medicaid reimbursement are also required to comply with the Wisconsin DHS (Department of Health Services) Affirmative Action and Civil Rights Compliance Plan requirements. Providers that employ 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 their goods and services available to and usable by people with disabilities to the extent that it is readily achievable to do so (to the extent that needed changes can be accomplished without much difficulty or expense)
2. Provide auxiliary aids and services so that people with sensory or cognitive disabilities have access to effective means of communication, unless doing so would fundamentally alter the operation or result in undue burdens
3. Modify any policies, practices, or procedures that may be discriminatory or have a discriminatory effect, unless doing so would fundamentally alter the nature of the goods, services, facilities, or accommodations
4. Ensure that there are no unnecessary eligibility criteria that tend to screen out or segregate individuals with disabilities or limit their full and equal enjoyment of the place of public accommodation

Age Discrimination Act of 1975

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

Topic #198

Contracted Staff

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

When contracting services, providers are required to ensure contracted agencies are qualified to provide services, meet all ForwardHealth and program requirements, and maintain records in accordance with the requirements for the provision of services.

Medicaid requirements do not relieve contracted agencies of their own regulatory requirements. Contracted agencies are required to continue to meet their own regulatory requirements, in addition to ForwardHealth requirements.

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

- Wisconsin Administrative Code
- ForwardHealth Updates
- The Online Handbook

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

Topic #216

Examples of Ongoing Responsibilities

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

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

Topic #217

Keeping Information Current

Changes That Require ForwardHealth Notification

Providers are required to notify ForwardHealth of any changes to their demographic information, including the following, as they occur:

- Address(es) — practice location and related information, mailing, PA (prior authorization), and/or financial

  Note: Health care providers who are federally required to have an NPI (National Provider Identifier) are cautioned that changes to their practice location address on file with ForwardHealth may alter their zip+4 code information that is required on transactions.

- Business name
- Contact name
- Federal Tax ID number (IRS (Internal Revenue Service) number)
- Group affiliation
- Licensure
- NPI
- Ownership
- Professional certification
- Provider specialty
- Supervisor of nonbilling providers
- Taxonomy code
- Telephone number, including area code

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

- Incorrect reimbursement

- Misdirected payment
- Claim denial
- Suspension of payments or cancellation of provider file if provider mail is returned to ForwardHealth for lack of a current address

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

Notifying ForwardHealth of Changes

Providers can notify ForwardHealth of changes using the demographic maintenance tool.

Providers Enrolled in Multiple Programs

If demographic information changes, providers enrolled in multiple programs (for example, Wisconsin Medicaid and WCDP (Wisconsin Chronic Disease Program)) will need to change the demographic information for each program. By toggling between accounts using the Switch Organization function of the Portal, providers who have a Portal account for each program can change their information for each program using the demographic maintenance tool. The Account User Guide provides specific information about switching organizations.

Providers Licensed or Certified by the Division of Quality Assurance

Providers licensed or certified by the DQA (Division of Quality Assurance) are required to notify the DQA of changes to physical address, changes of ownership, and facility closures by emailing Lisa.Imhof@dhs.wisconsin.gov.

Topic #577

Legal Framework

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

- Federal Law and Regulation:
  - Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI
  - Regulation — Title 42 C.F.R. Parts 430-498 and Parts 1000-1008 (Public Health)
- Wisconsin Law and Regulation:
  - Law — Wis. Stat. §§ 49.43–49.499, 49.665, and 49.473
  - Regulation — Wis. Admin. Code chs. DHS 101, 102, 103, 104, 105, 106, 107, and 108

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

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

Topic #2774

Physical Therapy, Occupational Therapy, and Speech and Language Pathology Administration and Regulations

The following laws and regulations provide the legal framework for PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services:

- Wis. Stat. § 15 gives general powers to examining boards that license PT, OT, and SLP providers.
- Wis. Stat. § 227 gives an agency the authority to promulgate rules.
- Wis. Stat. § 448 outlines the qualifications for licensure or certification of PT or OT providers.
- Wis. Stat. § 459 outlines the qualifications for licensure of SLP providers.
- Wis. Stat. § 448 and Wis. Admin. Code ch. PT define the scope of practice for PT providers.
- Wis. Stat. § 448 and Wis. Admin. Code ch. OT define the scope of practice for OT providers.
- Wis. Stat. § 459 and Wis. Admin. Code ch. HAS define the scope of practice for SLP providers.

Topic #17097

Licensure Information

Licensed providers are required to keep all licensure information, including license number, grant and expiration dates, and physical location as applicable (for example, hospital providers), current with ForwardHealth.

If providers do not keep their licensure information, including their license number, current with ForwardHealth, any of the following may occur:

- Providers' enrollment may be deactivated. As a result, providers would not be able to submit claims or PA (prior authorization) requests or be able to function as prescribing/referring/ordering providers, if applicable, until they update their licensure information.
- Providers may experience a lapse in enrollment. If a lapse occurs, providers may need to re-enroll, which may result in another application fee being assessed.

Providers may change the grant and expiration dates for their current license(s) and enter information for a new license(s), such as the license number, licensing state, and grant and expiration dates, using the demographic maintenance tool. After entering information for their new license(s), some providers (for example, out-of-state providers) will also be required to upload a copy of their license using the demographic maintenance tool. Provided licensure information must correspond with the information on file with the applicable licensing authority.

In some cases, ForwardHealth will need to verify licensure information with the applicable licensing authority, which may take up to 10 business days after submission. Providers updating their license information should plan accordingly so that they do not experience any of the indicated interruptions in enrollment. If provided licensure information (for example, grant and expiration dates) does not correspond with the licensing authority's information, the licensing authority's information will be retained and will display in the demographic maintenance tool once verified by ForwardHealth.

Topic #15157

Recovery Audit Contractor Audits

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

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

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

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

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

Affected Providers

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

Additional Information

Any questions regarding the RAC program should be directed to HMS at 855-699-6289. Refer to the RAC website for additional information regarding HMS RAC activities.

Topic #13277

Reporting Suspected Waste, Fraud, and Abuse

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

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

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

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

Reporting Suspected Fraud and Abuse

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

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

- Going to the OIG fraud and abuse reporting website
- Calling the DHS fraud and abuse hotline at 877-865-3432

The following information is helpful when reporting fraud and abuse:

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

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

Documentation

Topic #6277

1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than $600, per IRS (Internal Revenue Service) regulations. One 1099 Miscellaneous form per financial payer and per tax identification number is generated, regardless of how many provider IDs or NPIs (National Provider Identifier) share the same tax identification number. For example, a provider who conducts business with both Medicaid and WCDP (Wisconsin Chronic Disease Program) will receive separate 1099 Miscellaneous forms for each program.

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

Topic #1640

Availability of Records to Authorized Personnel

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

If Wisconsin Medicaid requires a provider to submit hard copies of records instead of scanning or accepting electronic records during a compliance audit, DHS reimburses providers $0.06 per page. A letter of request for records from DHS will be sent to a provider when records are required, with instructions on how to submit records electronically or if physical records are required.

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

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

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

Topic #200

Confidentiality and Proper Disposal of Records

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

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

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

HIPAA Privacy and Security Regulations

Definition of Protected Health Information

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

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

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

Requirements Regarding "Unsecured" Protected Health Information

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

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

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

Actions Required for Proper Disposal of Records

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

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

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

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

Wisconsin Confidentiality Laws

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

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

"Personally Identifiable Data" Protected

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

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

Actions Required for Proper Disposal of Records

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

Businesses Affected

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

Continuing Responsibilities for All Providers After Ending Participation

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

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

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

Penalties for Violations

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

- Fines up to $1.5 million per calendar year

- Jail time
- Federal HHS Office of Civil Rights enforcement actions

For entities not subject to HIPAA, Wis. Stat. § 34.97(4) imposes penalties for violations of confidentiality laws. Any provider or provider's business partner who violates Wisconsin confidentiality laws may be subject to fines up to $1,000 per incident or occurrence.

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

Topic #2779

Daily Entries

PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) providers are required to write a note in the member's medical record for every DOS (date of service). In the event of a provider audit, auditors will review any or all of the provider and member records that support reimbursement for services provided on a specific DOS. Records limited to checklists with attendance, procedure codes, and units of time are insufficient to meet this requirement. Daily entries must include the following:

- DOS
- Duration of the PT, OT, or SLP session
- Specific treatment activities/interventions provided and the corresponding procedure codes
- Problem(s) treated
- Objective measurement of the member's response to the services provided during the treatment session
- Signatures and credentials of the performing provider and, when necessary, the appropriate supervising therapist

If a PT, OT, or SLP session does not occur as scheduled, the provider is required to indicate the reason the session did not occur.

Topic #2778

Evaluations

PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) providers are required to include a written report of the member's evaluation in the member's medical record. The evaluation report must be signed and dated and include the following:

- Assessment of the member's condition and recommendations for therapy intervention
- Baseline measurements that establish a performance or ability level using units of objective measurement that can be consistently applied when reporting subsequent status of the member's progress
- Chronological history of treatment provided for the diagnosis
- Diagnosis(es) with date(s) of onset, current medical status, and functional status of the member
- List of other PT, OT, and SLP service providers who are currently treating the member to the extent known by the evaluating PT, OT, or SLP provider
- Procedures to be used in treatment. Providers may identify procedures with the applicable CPT (Current Procedural Terminology) code(s)
- Goals of treatment
- Previous level of function and change in medical status since previous PA (prior authorization) requests if performing a re-evaluation
- Reason for the referral

- Recommended frequency and duration of treatment
- Test charts or forms used in the evaluation, if applicable
- Underlying conditions or impairments to be treated

Topic #201

Financial Records

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

Topic #202

Medical Records

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

Topic #199

Member Access to Records

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

Fees for Health Care Records

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

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

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

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

Wisconsin DHS (Department of Health Services) adjusts the amounts a provider may charge for providing copies of a member's health care records yearly per Wis. Stat. § 146.83(3f)(c).

Topic #2777

Overview

As stated in Wis. Admin. Code § DHS 106.02(9), providers are required to prepare and maintain truthful, accurate, complete, legible, and concise medical documentation and financial records.

To be reimbursed by Wisconsin Medicaid, all PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services must be documented in the member's medical record. Documentation requirements include, but are not limited to, the following:

- The physician's prescription for PT, OT, and SLP services
- The written report of the member's evaluation
- The member's POC (plan of care)
- A written entry for each date a PT, OT, or SLP service is provided
- A discharge plan, including any applicable home exercise programs and maintenance plans

Topic #2776

Plan of Care

PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) providers are required to establish a written POC (plan of care) for all members before providing services. The POC must be promptly signed and dated by the prescribing physician and included in the member's medical record. The POC must include the following:

- Diagnoses
- Amount, frequency, duration, and specific PT, OT, or SLP services
- Reports of current status that support the POC
- Measurable objectives
- Anticipated short-term and long-term functional goals, which must be outcome based, appropriate for the diagnoses or presenting problems, and related to the specific PT, OT, and SLP services
- A reasonable estimate of when the goals will be achieved
- Communication and coordination with other providers, including such documentation as the following:
    - Date(s) of communication
    - Person(s) contacted
    - A brief summary of the PT, OT, and SLP services provided by the other providers
    - The unique and specific contribution of this PT, OT, or SLP provider given other PT, OT, and SLP providers' contributions

At least every 90 days, or earlier if necessary, both of the following must occur:

- Physical therapy, OT, and SLP providers are required to do one of the following:
    - Develop a new POC
    - Review and update the POC
- Physicians are required to sign and date the POC with each review.

Physician Review and Signature on Successive Plans of Care

All successive POC must be reduced to writing by the therapist and reviewed, signed, and dated by the prescribing physician at least every 90 days. The physician's signature and date on successive POC becomes the therapist's written order, and must be obtained prior to providing ongoing treatment. Should the severity of the member's condition require revision of the POC more frequently than every 90 days, the providing therapist is required to review and develop a new POC as frequently as the severity of the member's condition requires. Wisconsin Medicaid may deny or recoup reimbursement for services provided without a physician prescription or before a POC is established.

Plan of Care Requirements for Birth to 3 Program Participants

ForwardHealth requirements necessitate POC updates every 90 days in order to receive reimbursement for **all** members. Providers are reminded that this Medicaid requirement differs from the Birth to 3 Program which, per Wis. Admin. Code § DHS 90.10(7)(a), requires a review of the IFSP (Individualized Family Services Plan) POC at least every 6 months. Birth to 3 Program participants receiving services under ForwardHealth must have their POC updated every 90 days for reimbursement.

Topic #16157

Policy Requirements for Use of Electronic Signatures on Electronic Health Records

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

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

Electronic Signature Definition

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

Some examples include:

- Typed name (performer may type their complete name)
- Number (performer may type a number unique to them)
- Initials (performer may type initials unique to them)

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

Benefits of Using Electronic Signatures

The use of electronic signatures will allow providers to:

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

Electronic Signature Requirements

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

General Requirements

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

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

Electronic Health Record Signature Requirements

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

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

Topic #203

Preparation and Maintenance of Records

All providers who receive payment from Wisconsin Medicaid, including state-contracted MCOs (managed care organizations), are required to maintain records that fully document the basis of charges upon which all claims for payment are made, according to Wis. Admin. Code § DHS 106.02(9)(a). This required maintenance of records is typically required by any third-party

insurance company and is not unique to ForwardHealth.

Topic #2775

Prescription

To receive reimbursement for PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services, ForwardHealth requires a prescription. The prescription must be signed and dated by a physician and included in the member's medical record. The prescription is valid for one year or until a new POC (plan of care) is required.

Topic #204

Record Retention

Providers are required to retain documentation, including medical and financial records, for a period of not less than five years from the date of payment, except RHCs (rural health clinics), which are required to retain records for a minimum of six years from the date of payment.

According to Wis. Admin. Code § DHS 106.02(9)(d), providers are required to retain all evidence of billing information.

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

Maintaining Confidentiality of Records

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

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

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

Reviews and Audits

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

Topic #205

Records Requests

Requests for billing or medical claim information regarding services reimbursed by Wisconsin Medicaid may come from a variety of individuals including attorneys, insurance adjusters, and members. Providers are required to notify ForwardHealth when

releasing billing information or medical claim records relating to charges for covered services except in the following instances:

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

Request From a Member or Authorized Person

If the request for a member's billing information or medical claim records is from a member or authorized person acting on behalf of a member, the provider is required to do the following:

1. Send a copy of the requested billing information or medical claim records to the requestor.
2. Send a letter containing the following information to ForwardHealth:
    - Member's name
    - Member's ForwardHealth identification number or SSN (Social Security number), if available
    - Member's DOB (date of birth)
    - DOS (date of service)
    - Entity requesting the records, including name, address, and telephone number

    The letter must be sent to the following address:

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

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

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

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

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

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

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

1. Obtain a release signed by the member or authorized representative.

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

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

Request for a Statement From a Dual Eligible

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

Topic #1646

Release of Billing Information to Government Agencies

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

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

Communication

Topic #2781

Requirements

BadgerCare Plus PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) providers are required to communicate with other providers as frequently as necessary to do the following:

- Avoid duplication of services
- Ensure service coordination
- Facilitate continuity of care

Other providers include, but are not limited to, the following:

- County Birth to 3 programs
- Community mental health agencies
- Home care agencies
- In-home autism providers
- Local health departments
- Medicaid HMOs
- Medical equipment vendors
- Physician clinics
- Rehabilitation agencies
- SBS (School-Based Services) providers
- Therapists
- Tribal health agencies

Providers are required to document their communication with other providers in all members' medical records.

Topic #2784

Coordination With SBS Providers

A school-aged member (ages 3 up to 21) who receives SBS may also receive PT, OT, and SLP services in the community that are not a part of the SBS. PT, OT, and SLP providers are required to coordinate evaluations and services with SBS providers. PT, OT, and SLP providers, along with SBS providers, are required to communicate with each other at least once a year. SBS providers are required to cooperate with PT, OT, and SLP providers who request copies of the child's IEP (Individualized Education Plan) or components of the IEP team evaluation.

Providers are required to maintain documentation of coordination of care in the member's medical record.

Topic #2785

Coordination With County Birth to 3 Programs

Per Title 34 C.F.R. Part 303, PT, OT, and SLP providers are required to refer children who may be eligible for Birth to 3 Program services to the appropriate county Birth to 3 Program within two working days of identification.

When a Birth to 3 Program is involved with a child (either for eligibility determination or service delivery), PT, OT, and SLP providers are required to cooperate with Birth to 3 Program service coordination.

Provider Rights

Topic #208

A Comprehensive Overview of Provider Rights

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

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

Topic #207

Ending Participation

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

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

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

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

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

Wisconsin Medicaid
Provider Enrollment
313 Blettner Blvd
Madison WI 53784

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

Topic #209

Hearing Requests

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

required under Wis. Stat. ch. DHS 227, may request a hearing by writing to the DHA (Division of Hearings and Appeals).

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

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

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

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

Topic #210

Limiting the Number of Members

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

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

Topic #206

Requesting Discretionary Waivers and Variances

In rare instances, a provider or member may apply for, and DMS (Division of Medicaid Services) will consider applications for, a discretionary waiver or variance of certain rules in Wis. Admin. Code chs. DHS 102, 103, 104, 105, 107, and 108. Rules that are not considered for a discretionary waiver or variance are included in Wis. Admin. Code § DHS 106.13.

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

Requirements

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

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

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

Application

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

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

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

Division of Medicaid Services
Waivers and Variances
PO Box 309
Madison WI 53701-0309

Sanctions

Topic #211

Intermediate Sanctions

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

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

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

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

Topic #212

Involuntary Termination

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

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

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

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

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

Topic #213

Sanctions for Collecting Payment From Members

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

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

Topic #214

Withholding Payments

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

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

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

Provider Numbers

Topic #3421

Provider Identification

Health Care Providers

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

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

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

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

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

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

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

Non-Healthcare Providers

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

Topic #5096

Taxonomy Codes

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

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

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

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

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

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

Topic #5097

ZIP Code

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

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

Providers may verify the zip+4 code for their address on the U.S. Postal Service website.

Covered and Noncovered Services

2

Archive Date:07/01/2025

Covered and Noncovered Services:Noncovered Services

Topic #68

Definition of Noncovered Services

A noncovered service is a service, item, or supply for which reimbursement is not available. Wis. Admin. Code § DHS 101.03 (103) and Wis. Admin. Code ch. 107 contain more information about noncovered services. In addition, Wis. Admin. Code § DHS 107.03 contains a general list of noncovered services.

Topic #104

Member Payment for Noncovered Services

A provider may collect payment from a member for noncovered services if certain conditions are met.

Providers may not collect payment from a member (or authorized person acting on behalf of the member) for certain noncovered services or activities provided in connection with covered services, including:

- Charges for missed appointments
- Charges for telephone calls
- Charges for time involved in completing necessary forms, claims, or reports
- Translation services

Missed Appointments

Federal CMS (Centers for Medicare and Medicaid Services) does not allow state Medicaid programs to permit providers to collect payment from a member, or authorized person acting on behalf of the member, for a missed appointment.

Avoiding Missed Appointments

ForwardHealth offers the following suggestions to help avoid missed appointments:

- Remind members of upcoming appointments (by telephone or postcard) prior to scheduled appointments.
- If a member needs assistance in obtaining transportation to a medical appointment, encourage the member to call the NEMT (non-emergency medical transportation) manager contracted with Wisconsin DHS (Department of Health Services). Most Medicaid and BadgerCare Plus members may receive NEMT services through the NEMT manager if they have no other way to receive a ride. Refer to the NEMT service area for more information.
- If the appointment is made through the HealthCheck screening or targeted case management programs, encourage the staff from those programs to ensure that the scheduled appointments are kept.

Translation and Interpretive Services

Translation services, which refer to translation of the written word, are considered part of the provider's overhead cost and are not separately reimbursable. Providers may not collect payment from a member (or authorized person acting on behalf of the member) for translation services.

Interpretive services, which refer to interpretation of the spoken word or sign language, are a covered service. More information

on interpretive services can be found in the Interpretive Services topic.

Providers should call the Affirmative Action and Civil Rights Compliance Officer at 608-266-9372 for information about when translation services are required by federal law. Providers may also write to the following address:

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

HealthCheck "Other Services"

Topic #22

Definition of HealthCheck Other Services

HealthCheck is the term used for EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) in Wisconsin. The HealthCheck benefit provides periodic, comprehensive health screening exams (also known as well child checks), as well as interperiodic screens, outreach and case management, and additional medically necessary services (referred to as HealthCheck Other Services) for members under 21 years of age.

Wisconsin Medicaid covers most diagnostic and intervention services a member may need. However, federal law requires that states provide any additional health care services that are coverable under the federal Medicaid program and found to be medically necessary to treat, correct, or reduce illnesses and conditions discovered regardless of whether or not the service is covered in a state's Medicaid program. HealthCheck Other Services is Wisconsin's term for this federal requirement.

The requested service must be allowable under federal Medicaid law, per § 1905(a) of the Social Security Act, and must be medically necessary and reasonable for the member to be covered by Wisconsin Medicaid, per Wis. Admin. Code § DHS 107.02(3)(e). Most HealthCheck Other Services require PA (prior authorization) per Wis. Admin. Code § DHS 107.02.

Topic #1

Prior Authorization for HealthCheck "Other Services"

Providers submitting PA (prior authorization) requests for HealthCheck "Other Services" should review the two types of PA requests. The following types of PA requests have their own submission requirements:

- Requests for exceptions to coverage limitations
- Requests for federally allowable Medicaid services not routinely covered by Wisconsin Medicaid

PA Submission Requirements for Exceptions to Coverage Limitations

HealthCheck "Other Services" may additionally cover established Medicaid health care services that are limited in coverage for members under 21 years of age.

If a PA request is submitted requesting additional coverage for a benefit where there is established policy, the request is automatically processed under the HealthCheck "Other Services" benefit to evaluate whether the requested service is likely to correct or ameliorate the member's condition, including maintaining current status or preventing regression.

Examples of coverage limitations include service amounts that are prohibited by policy, or the requested service is not expected to result in a favorable improvement in the member's condition or diagnosis.

Every PA request for a member under age 21 is first processed according to standard Medicaid guidelines and then reviewed under HealthCheck "Other Services" guidelines. For these reasons, providers do **not** need to take additional action to identify the PA request as a HealthCheck "Other Services" request.

If an established benefit will be requested at a level that exceeds Wisconsin Medicaid coverage limits, in addition to the required PA documentation detailed in the appropriate service area of the Online Handbook, the request should provide:

- The rationale detailing why standard coverage is not considered acceptable to address the identified condition.
- The rationale detailing why the requested service is needed to correct or ameliorate the member's condition.

PA Submission Requirements for Services Not Routinely Covered by Wisconsin Medicaid

HealthCheck "Other Services" allows coverage of health care services that are not routinely covered by Wisconsin Medicaid, but are federally allowable and medically necessary to maintain, improve, or correct the member's physical and mental health, per § 1905(a) of the Social Security Act. These HealthCheck "Other Services" require PA since the determination of medical necessity is made on a case-by-case basis depending on the needs of the member.

If a PA request is submitted requesting coverage for a service that does not have established policy and is not an exception to coverage limitations, the provider is required to identify the PA as a HealthCheck "Other Services" request by **checking the HealthCheck "Other Services" box** and submit the following information:

- A current, valid order or prescription for the service being requested:
  - Prescriptions are valid for 12 or fewer months from the date of the signature (depending on the service area).
  - Updated prescriptions may be required more frequently for some benefits.
- A completed PA/RF (Prior Authorization Request Form, F-11018 (05/2013)), for most service areas, including the following:
  - For Element 1, **check the HealthCheck "Other Services" box.**
  - For Element 19, enter the procedure code that most accurately describes the service, even if the code is not ordinarily covered by Wisconsin Medicaid. Unlisted procedure codes can be requested if the service is not accurately described by existing procedure codes.
  - For Element 20, enter informational procedure code modifier EP (Service provided as part of Medicaid early periodic screening diagnosis and treatment [EPSDT] program) to indicate that the service is requested as a HealthCheck "Other Services" benefit.
  - For Element 22, include the description of the service.
- A completed PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/2012)), or PA/HIAS1 (Prior Authorization Request for Hearing Instrument and Audiological Services, F-11020 (05/2013)) when the PA/RF is not applicable
- A PA attachment form(s) for the related service area, if known, or clinical documentation substantiating the medical necessity of the requested procedure code and:
  - The rationale detailing why services typically covered by Wisconsin Medicaid are not considered acceptable to address the identified condition or why services were discontinued.
  - The rationale detailing why the requested service is needed to correct or ameliorate the member's condition.

  Note: Providers may call Provider Services to determine the appropriate PA attachment.

- Evidence the requested service is clinically effective and not harmful (If the requested service is new to Wisconsin Medicaid, additional documentation regarding current research and/or safety of the intervention may be submitted.)
- The MSRP (manufacturer's suggested retail price) for requested equipment or supplies
- The 11-digit NDC (National Drug Code) for any requested OTC (over-the-counter) drugs on pharmacy PA requests

Providers may call Provider Services for more information about HealthCheck "Other Services."

If the PA request is incomplete or additional information is needed to substantiate the necessity of the requested service, the PA request will be returned to the provider. **A return for more information is not a denial.**

Topic #41

Requirements

For a service to be reimbursed through HealthCheck "Other Services," the following requirements must be met:

- The service is provided to a member who is under 21 years of age.
- The service is coverable under federal Medicaid law.
- The service is medically necessary and reasonable.
- The service is prior authorized before it is provided.
- Services currently available are not considered acceptable to treat the identified condition.

ForwardHealth has the authority to do all of the following:

- Review the medical necessity of all requests.
- Establish criteria for the provision of such services.
- Determine the amount, duration, and scope of services as long as the authorized amount is reasonable and maintains the preventive intent of the HealthCheck benefit.

HealthCheck "Other Services" does not include reimbursement in excess of ForwardHealth published maximum allowable fees.

All PA (prior authorization) requests must follow NCCI (National Correct Coding Initiative) guidelines.

Codes

Topic #2753

Modifiers

Allowable modifiers for PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services are listed in the following table.

Therapy Discipline	Modifier	Description	Notes
OT	GO	Services delivered personally by an occupational therapist or under an outpatient OT POC (plan of care)	Modifier GO should only be indicated when submitting PA requests or claims for services rendered by a licensed occupational therapist, a certified OT assistant, or an OT student. (All relevant supervision requirements must be met for services rendered by assistants or students.)
PT	GP	Services delivered personally by a physical therapist or under an outpatient PT POC	Modifier GP should only be indicated when submitting PA requests or claims for services rendered by a licensed physical therapist, a physical therapist assistant, a PT aide, or a PT student. (All relevant supervision requirements must be met for services rendered by assistants, aides, or students.)
SLP	GN	Services delivered personally by a speech and language pathologist or under an outpatient SLP POC	Modifier GN should only be indicated when submitting PA requests or claims for services rendered by a licensed speech and language pathologist, an SLP provider assistant, or an SLP student. (All relevant supervision requirements must be met for services rendered by assistants or students.)
PT and OT	TF	Intermediate level of care	Modifier TF should be indicated when submitting claims for services provided by physical therapist assistants or certified OT assistants under general supervision. TF should not be indicated on PA (prior authorization) requests.
PT, OT, and SLP	TL	Early intervention/IFSP (Individualized Family Service Plan)	Modifier TL should be indicated when submitting claims for Birth to 3 services provided in the natural environment of a Birth to 3 member. TL should not be indicated on PA requests.

Providers are required to indicate modifier TL when submitting claims for natural environment-enhanced reimbursement when providing services to members in the Birth to 3 Program. Providers are required to indicate the TL modifier for each detail line that they wish the reimbursement to be considered.

Providers are required to indicate modifier TF when submitting claims for services provided by an assistant therapist.

Topic #2793

Occupational Therapy Procedure Codes

Covered OT (occupational therapy) services are identified by the allowable CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) procedures codes listed in the following table.

Note: Procedure codes for many OT services are defined as 15 minutes. One unit of these codes = 15 minutes. If less than 15 minutes is used, bill in decimals. For example, 7.5 minutes = .5 units. All other procedure codes for OT services do not have a time increment indicated in their description. For these procedure codes, a quantity of "1" indicates a complete service.

General Casting	
Procedure Code	**Description**
29065	Application, cast; shoulder to hand (long arm)
29075	elbow to finger (short arm)
29085	hand and lower forearm (gauntlet)
29086	finger (eg, contracture)
29345	Application of long leg cast (thighs to toes)
29355	walker or ambulatory type
29365	Application of cylinder cast (thigh to ankle)
29405	Application of short leg cast (below knee to toes);
29425	walker or ambulatory type
29445	Application of rigid total contact leg cast

Casting Supply	
Procedure Code	**Description**
Q4003	Cast supplies, shoulder cast, adult (11 years +), plaster
Q4004	Cast supplies, shoulder cast, adult (11 years +), fiberglass
Q4005	Cast supplies, long arm cast, adult (11 years +), plaster
Q4006	Cast supplies, long arm cast, adult (11 years +), fiberglass
Q4007	Cast supplies, long arm cast, pediatric (0–10 years), plaster
Q4008	Cast supplies, long arm cast, pediatric (0–10 years), fiberglass
Q4009	Cast supplies, short arm cast, adult (11 years +), plaster
Q4010	Cast supplies, short arm cast, adult (11 years +), fiberglass
Q4011	Cast supplies, short arm cast, pediatric (0–10 years), plaster
Q4012	Cast supplies, short arm cast, pediatric (0–10 years), fiberglass
Q4013	Cast supplies, gauntlet cast (includes lower forearm and hand), adult (11 years +), plaster
Q4014	Cast supplies, gauntlet cast (includes lower forearm and hand), adult (11 years +), fiberglass
Q4015	Cast supplies, gauntlet cast (includes lower forearm and hand), pediatric (0–10 years), plaster
Q4016	Cast supplies, gauntlet cast (includes lower forearm and hand), pediatric (0–10 years), fiberglass

Q4025	Cast supplies, hip spica (one or both legs), adult (11 years +), plaster
Q4026	Cast supplies, hip spica (one or both legs), adult (11 years +), fiberglass
Q4027	Cast supplies, hip spica (one or both legs), pediatric (0–10 years), plaster
Q4028	Cast supplies, hip spica (one or both legs), pediatric (0–10 years), fiberglass
Q4029	Cast supplies, long leg cast, adult (11 years +), plaster
Q4030	Cast supplies, long leg cast, adult (11 years +), fiberglass
Q4031	Cast supplies, long leg cast, pediatric (0–10 years), plaster
Q4032	Cast supplies, long leg cast, pediatric (0–10 years), fiberglass
Q4033	Cast supplies, long leg cylinder cast, adult (11 years +), plaster
Q4034	Cast supplies, long leg cylinder cast, adult (11 years +), fiberglass
Q4035	Cast supplies, long leg cylinder cast, pediatric (0–10 years), plaster
Q4036	Cast supplies, long leg cylinder cast, pediatric (0–10 years), fiberglass
Q4037	Cast supplies, short leg cast, adult (11 years +), plaster
Q4038	Cast supplies, short leg cast, adult (11 years +), fiberglass
Q4039	Cast supplies, short leg cast, pediatric (0–10 years), plaster
Q4040	Cast supplies, short leg cast, pediatric (0–10 years), fiberglass

Evaluations	
Procedure Code	**Description**
97165*	Occupational therapy evaluation, low complexity, requiring these components: - An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; - An assessment[s] that identifies one to three performance deficits [eg, relating to physical, cognitive, or psychosocial skills] that result in activity limitations and/or participation restrictions; and - Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment[s], and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance [eg, physical or verbal] with assessment[s] is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face to face with the patient and/or family.
97166*	Occupational therapy evaluation, moderate complexity, requiring these components: - An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; - An assessment[s] that identifies three to five performance deficits [eg, relating to physical, cognitive, or psychosocial skills] that result in activity limitations and/or participation restrictions; and

	▪ Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment[s], and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance [eg, physical or verbal] with assessment[s] is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face to face with the patient and/or family.
97167*	Occupational therapy evaluation, high complexity, requiring these components: ▪ An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive review of physical, cognitive, or psychosocial history related to current functional performance; ▪ An assessment[s] that identifies five or more performance deficits [eg, relating to physical, cognitive, or psychosocial skills] that result in activity limitations and/or participation restrictions; and ▪ Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment[s], and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance [eg, physical or verbal] with assessment[s] is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face to face with the patient and/or family.
97168*	Re-evaluation of occupational therapy established plan of care, requiring these components: ▪ An assessment of changes in patient functional or medical status with revised plan of care; ▪ An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and ▪ A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face to face with the patient and/or family.

Therapeutic Procedures	
Procedure Code	**Description**
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97124	massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive

	function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)
97139	Unlisted therapeutic procedure (specify)
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes
97597*	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters
97598*	Total wound(s) surface area greater than 20 square centimeters
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

Modalities	
Procedure Code	**Description**
90901	Biofeedback training by any modality
97016	Application of modality to one or more areas; vasopneumatic devices
97018	paraffin bath
97022	whirlpool
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes

97033	iontophoresis, each 15 minutes
97034	contrast baths, each 15 minutes
97035	ultrasound, each 15 minutes

* Procedure may not be provided by an occupational therapist assistant.

A unit of time is attained when the mid-point is passed. Providers should refer to the CPT guidelines for direction on reporting units on time-based and non-time-based procedures.

The same modality may not be reimbursed as a PT (physical therapy) service and an OT service on the same date of service for the same member.

E-Visits and Virtual Check-Ins	
Procedure Code	**Description**
G2250	Remote assessment of recorded video and/or images submitted by an established patient (eg, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous seven days nor leading to a service or procedure within the next 24 hours or soonest available appointment
G2251	Brief communication technology-based service (eg, virtual check-in), by a qualified health care professional who cannot report Evaluation and Management services, provided to an established patient, not originating from a related service provided within the previous seven days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of clinical discussion
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 5–10 minutes
98971	Qualified nonphysician health care professional online digital assessment and management service, for an established patient, for up to seven days, cumulative time during the seven days; 11–20 minutes
98972	Qualified nonphysician health care professional online digital assessment and management service, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes

Topic #2792

Physical Therapy Procedure Codes

Covered PT (physical therapy) services are identified by the allowable CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) procedures codes listed in the following table.

General Casting	
Procedure Code	**Description**
29065	Application, cast; shoulder to hand (long arm)
29075	elbow to finger (short arm)
29085	hand and lower forearm (gauntlet)
29086	finger (eg, contracture)

29345	Application of long leg cast (thighs to toes)
29355	walker or ambulatory type
29365	Application of cylinder cast (thigh to ankle)
29405	Application of short leg cast (below knee to toes);
29425	walker or ambulatory type
29445	Application of rigid total contact leg cast

Casting Supply	
Procedure Code	**Description**
Q4003	Cast supplies, shoulder cast, adult (11 years +), plaster
Q4004	Cast supplies, shoulder cast, adult (11 years +), fiberglass
Q4005	Cast supplies, long arm cast, adult (11 years +), plaster
Q4006	Cast supplies, long arm cast, adult (11 years +), fiberglass
Q4007	Cast supplies, long arm cast, pediatric (0–10 years), plaster
Q4008	Cast supplies, long arm cast, pediatric (0–10 years), fiberglass
Q4009	Cast supplies, short arm cast, adult (11 years +), plaster
Q4010	Cast supplies, short arm cast, adult (11 years +), fiberglass
Q4011	Cast supplies, short arm cast, pediatric (0–10 years), plaster
Q4012	Cast supplies, short arm cast, pediatric (0–10 years), fiberglass
Q4013	Cast supplies, gauntlet cast (includes lower forearm and hand), adult (11 years +), plaster
Q4014	Cast supplies, gauntlet cast (includes lower forearm and hand), adult (11 years +), fiberglass
Q4015	Cast supplies, gauntlet cast (includes lower forearm and hand), pediatric (0–10 years), plaster
Q4016	Cast supplies, gauntlet cast (includes lower forearm and hand), pediatric (0–10 years), fiberglass
Q4025	Cast supplies, hip spica (one or both legs), adult (11 years +), plaster
Q4026	Cast supplies, hip spica (one or both legs), adult (11 years +), fiberglass
Q4027	Cast supplies, hip spica (one or both legs), pediatric (0–10 years), plaster
Q4028	Cast supplies, hip spica (one or both legs), pediatric (0–10 years), fiberglass
Q4029	Cast supplies, long leg cast, adult (11 years +), plaster
Q4030	Cast supplies, long leg cast, adult (11 years +), fiberglass
Q4031	Cast supplies, long leg cast, pediatric (0–10 years), plaster
Q4032	Cast supplies, long leg cast, pediatric (0–10 years), fiberglass
Q4033	Cast supplies, long leg cylinder cast, adult (11 years +), plaster
Q4034	Cast supplies, long leg cylinder cast, adult (11 years +), fiberglass
Q4035	Cast supplies, long leg cylinder cast, pediatric (0–10 years), plaster
Q4036	Cast supplies, long leg cylinder cast, pediatric (0–10 years), fiberglass
Q4037	Cast supplies, short leg cast, adult (11 years +), plaster
Q4038	Cast supplies, short leg cast, adult (11 years +), fiberglass
Q4039	Cast supplies, short leg cast, pediatric (0–10 years), plaster

Q4040	Cast supplies, short leg cast, pediatric (0–10 years), fiberglass

Evaluations	
Procedure Code	**Description**
97161	Physical therapy evaluation: low complexity, requiring these components: - A history with no personal factors and/or comorbidities that impact the plan of care; - An examination of body system[s] using standardized tests and measures addressing one to two elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; - A clinical presentation with stable and/or uncomplicated characteristics; and - Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face to face with the patient and/or family.
97162	Physical therapy evaluation: moderate complexity, requiring these components: - A history of present problem with one to two personal factors and/or comorbidities that impact the plan of care; - An examination of body system[s] using standardized tests and measures addressing a total of three or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; - An evolving clinical presentation with changing characteristics; and - Clinical decision making of moderate complexity using measurable assessment of functional outcome. Typically, 30 minutes are spent face to face with the patient and/or family.
97163	Physical therapy evaluation: high complexity, requiring these components: - A history of present problem with three or more personal factors and/or comorbidities that impact the plan of care; - An examination of body systems using standardized tests and measures addressing a total of four or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; - A clinical presentation with unstable and unpredictable characteristics; and - Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face to face with the patient and/or family.
97164	Re-evaluation of physical therapy established plan of care, requiring these components: - An examination including a review of history and use of standardized tests and measures is required;

	and - Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face to face with the patient and/or family.

Modalities	
Procedure Code	**Description**
G0281	Electrical stimulation, (unattended), to one or more areas, for chronic stage iii and stage iv pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care
G0282	Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
90901	Biofeedback training by any modality
97012	Application of a modality to one or more areas; traction, mechanical
97016	vasopneumatic devices
97018	paraffin bath
97022	whirlpool
97024	diathermy (eg, microwave)
97026	infrared
97028	ultraviolet
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	iontophoresis, each 15 minutes
97034	contrast baths, each 15 minutes
97035	ultrasound, each 15 minutes
97036	Hubbard tank, each 15 minutes
97039	Unlisted modality (specify type and time if constant attendance)

Therapeutic Procedures	
Procedure Code	**Description**
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	aquatic therapy with therapeutic exercises
97116	gait training (includes stair climbing)
97124	massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97139	Unlisted therapeutic procedure (specify)

97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (two or more individuals) (Report 97150 for each member of the group) (Group Therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one member contact by the physician or therapist)
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes
97597	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters
97598	total wound(s) surface area greater than 20 square centimeters
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

E-Visits and Virtual Check-ins	
Procedure Code	**Description**
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 5–10 minutes
98971	Qualified nonphysician health care professional online digital assessment and management service, for an established patient, for up to seven days, cumulative time during the seven days; 11–20 minutes
98972	Qualified nonphysician health care professional online digital assessment and management service, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes
G2250	Remote assessment of recorded video and/or images submitted by an established patient (eg, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous seven days nor leading to a service or procedure within the next 24 hours or soonest available appointment
G2251	Brief communication technology-based service (eg, virtual check-in) by a qualified health care professional who cannot report Evaluation and Management services, provided to an established patient, not originating

	from a related service provided within the previous seven days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of clinical discussion

Other Procedures	
Procedure Code	**Description**
93797	Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
93798	with continuous ECG monitoring (per session)
94667	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation
94668	subsequent

A unit of time is attained when the mid-point is passed. Providers should refer to the CPT guidelines for direction on reporting units on time-based and non-time-based procedures.

The same modality may not be reimbursed as a PT service and an OT (occupational therapy) service on the same DOS (date of service) for the same member.

Topic #2752

Place of Service Codes

Allowable POS (place of service) codes for PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) are listed in the following table.

POS Code	Description
02	Telehealth Provided Other Than in Patient's Home
04*	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
10	Telehealth Provided in Patient's Home
11	Office
12*	Home
15	Mobile Unit
19	Off Campus—Outpatient Hospital
20	Urgent Care Facility
21	Inpatient Hospital
22	On Campus—Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility

34	Hospice
50	Federally Qualified Health Center
54	Intermediate Care Facility/Individuals With Intellectual Disabilities
71	Public Health Clinic
72	Rural Health Clinic
99*	Other Place of Service

* POS codes 04, 12, and 99 are eligible for the natural environment enhanced reimbursement when providing services to members who participate in the Birth to 3 Program when the natural environment modifier is indicated on the claim.

Topic #2794

Speech and Language Pathology Procedure Codes

Allowable SLP (speech and language pathology) services are identified by the allowable CPT (Current Procedural Terminology) procedure codes listed in the following table.

Note: All codes listed in this chart, if billed with an applicable POS (place of service) code, are eligible for natural environment enhanced reimbursement. Providers may not submit claims for services for less than eight minutes. Most procedure codes for SLP services do not have a time increment indicated in their description. Except as previously noted, a quantity of "1" indicates a complete service. The daily service limitation for these codes is one.

Procedure Code	Description	Billing Limitations	ForwardHealth Coverage Criteria
G2250	Remote assessment of recorded video and/or images submitted by an established patient (eg, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous seven days nor leading to a service or procedure within the next 24 hours or soonest available appointment	• Cannot take place during an in-person visit. • Cannot take place within seven days after an in-person visit furnished by the same provider. • Cannot trigger an in-person visit within 24 hours or the soonest	These services do not require prior authorization and are patient-initiated by established patients of the provider's practice.

		available appointment. - Do not have sufficient information from the remote evaluation of an image or video (store and forward) for the provider to complete the service. Only the relevant in-person procedure code that was rendered would be reimbursed if any of the above conditions apply.	
G2251	Brief communication technology-based service (eg, virtual check-in), by a qualified health care professional who cannot report Evaluation and Management services, provided to an established patient, not originating from a related service provided within the previous seven days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of	- Cannot take place during an in-person visit. - Cannot take place within seven days after an in-person visit furnished by the same provider. - Cannot trigger an in-person visit	These services do not require prior authorization and are patient-initiated by established patients of the provider's practice.

	clinical discussion	within 24 hours or the soonest available appointment. - Do not have sufficient information from the remote evaluation of an image or video (store and forward) for the provider to complete the service. Only the relevant in-person procedure code that was rendered would be reimbursed if any of the above conditions apply.	
31575	Laryngoscopy, flexible; diagnostic		Use this code if the speech-language pathologist actually inserts a laryngoscope. Do not use this code if the speech-language pathologist is providing an analysis and does not insert the laryngoscope; instead, use code 92506 or 92610, as appropriate. For treatment, use 92507 or 92526, as appropriate. This service is to be performed according to the ASHA (American Speech-Language-Hearing Association) Code of Ethics and ASHA Training Guidelines for Laryngeal Videoendoscopy/Stroboscopy.
31579	Laryngoscopy, flexible or rigid telescopic, with stroboscopy		Use this code if the speech-language pathologist actually inserts a laryngoscope. Do not use this code if the speech-language pathologist is providing an analysis and does not insert the

			laryngoscope; instead, use code 92506 or 92610, as appropriate. This service is to be performed according to the ASHA Code of Ethics and ASHA Training Guidelines for Laryngeal Videoendoscopy/Stroboscopy.
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder		This code should be used for therapy services that address communication/cognitive impairments, voice prosthetics, and auditory rehabilitation.
92507 + UC*	Treatment of speech, language, voice, communication, and/or auditory processing disorder		Use this code for aural rehabilitation following a cochlear implant.
92508	group, two or more individuals		"Group speech/language pathology treatment" means the delivery of SLP treatment procedures limited to the areas of expressive language, receptive language, and hearing/auditory training (auditory training, lip reading, and hearing-aid orientation), in a group setting for up to four BadgerCare Plus members (per Wis. Admin. Code § DHS 101.03[69]).
92511	Nasopharyngoscopy with endoscope (separate procedure)		Use this code if the speech-language pathologist actually inserts an endoscope. Do not use this code if the speech-language pathologist is providing an analysis and does not insert the scope; instead, use code 92506 or 92610, as appropriate. Use this code for evaluation of dysphagia or assessment of velopharyngeal insufficiency or incompetence. This service is to be performed according to the ASHA Code of Ethics and ASHA Training Guidelines for Laryngeal Videoendoscopy/Stroboscopy.
92512	Nasal function studies (eg, rhinomanometry)		Use this code if completing aerodynamic studies, oral pressure/nasal airflow, flow/flow studies, or pressure/pressure studies.
92520	Laryngeal function studies (eg, aerodynamic testing and acoustic testing)		Use this code for laryngeal airflow studies, subglottic air pressure studies, acoustic analysis, EGG (electroglottography) laryngeal resistance.
92521	Evaluation of speech fluency (eg, stuttering, cluttering)		Evaluation must provide a quantitative and/or qualitative description of the member's fluency level and/or evaluation must provide a measurement of speaking rate such as SPM (syllables per minute). Member's fluency may be documented through results of a commercial stuttering severity instrument and/or description of frequency and severity, types of

			dysfluencies, secondary characteristics, and self-awareness/perception/self-correction.
92522	Evaluation of speech sound productions (eg, articulation, phonological process, apraxia, dysarthria)	Not allowed on the same DOS (date of service) as 92523.	Evaluation must provide a quantitative and/or qualitative description of member's speech intelligibility. Member's speech sound production may be documented using results of standardized tests, reporting percent of intelligibility by familiar and unfamiliar listeners when context is known and unknown, and/or describing signs and symptoms of disordered sound production.
92523	with evaluation of language comprehension and expression (eg, receptive and expressive language)	Not allowed on the same DOS as 92522. If the member is evaluated **only** for language, procedure code 92523 should be billed with modifier 52.	Evaluation must provide a quantitative and/or qualitative description of member's speech intelligibility. Member's abilities may be documented using results of standardized tests, reporting percent of intelligibility by familiar and unfamiliar listeners when context is known and unknown, and/or reporting signs and symptoms of disordered sound production **and** report of member's receptive and expressive language abilities using standardized test results, norm referenced data, developmental levels, and/or estimate of language age-equivalent levels if formal testing is unable to be completed.
92524	Behavioral and qualitative analysis of voice and resonance		Evaluation must provide a quantitative and/or qualitative measurement of the member's voice and resonance including but not limited to perceptual ratings of voice quality, pitch, and loudness, and description of member's awareness of vocal problem, and phonatory behaviors. This procedure does not include instrumental assessment.
92526	Treatment of swallowing dysfunction and/or oral function for feeding		The member must have an identified physiological swallowing and/or feeding problem. This is to be documented using professional standards of practice such as identifying oral phase, esophageal phase, or pharyngeal phase dysphagia, baseline of current swallowing and feeding skills not limited to signs of aspiration, an oral mechanism exam, report of how nutrition is met, current diet restrictions, compensation strategies used, and level of assistance needed.
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	Cannot use on the same DOS as 96105.	This code describes the services to evaluate a member for the use of a voice prosthetic device (for example, electrolarynx, tracheostomy-speaking valve). Evaluation of picture communication books, manual picture boards, sign language,

			the Picture Exchange Communication System, picture cards, gestures, etc., are not included in the reimbursement for this code. Instead, use code 92506.
92607**	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	Cannot use on the same DOS as 96105.	This code describes the services to evaluate a member to specify the speech-generating device recommended to meet the member's needs and capacity. This can also be used for re-evaluations. Evaluation of picture communication books, manual picture boards, sign language, the Picture Exchange Communication System, picture cards, gestures, etc., are not included in the reimbursement for this code. Instead, use code 92506.
92608***	each additional 30 minutes (List separately in addition to code for primary procedure)	This code can be billed only in conjunction with 92607.	The maximum allowable number of units for this service is one unit of 92607 and one unit of 92608 (that is, a maximum of 90 minutes).
92609	Therapeutic services for the use of speech-generating device, including programming and modification		This code describes the face-to-face services delivered to the member to adapt the device to the member and train him or her in its use.
92610	Evaluation of oral and pharyngeal swallowing function		
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording		Accompanying a member to a swallow study is not reimbursable. This code involves participation and interpretation of results from the dynamic observation of the member swallowing materials of various consistencies. It is observed fluoroscopically and typically recorded on video. The evaluation involves using the information to assess the member's swallowing function and to develop a treatment.
92612	Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording;		
92614	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording;	Only allowable when used in conjunction with 92612.	
92626	Evaluation of auditory		

	function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour		
92627	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (List separately in addition to code for primary procedure)		
92700	Unlisted otorhinolaryngological service or procedure		PA (prior authorization) is always required to use this code. Use this code when no other CPT code description appropriately describes the evaluation or treatment.
96105**	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing [eg, by Boston Diagnostic Aphasia Examination]) with interpretation and report, per hour	Cannot use on the same DOS as 92506, 92597, 92607, or 92608.	
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating,		

	organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes		
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)		
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 5–10 minutes	- Cannot take place during an in-person visit. - Cannot take place within seven days after an in-person visit furnished by the same provider. - Cannot trigger an in-person visit within 24 hours or the soonest available	These services do not require prior authorization and are patient-initiated by established patients of the provider's practice.

		appointment. - Do not have sufficient information from the remote evaluation of an image or video (store and forward) for the provider to complete the service. Only the relevant in-person procedure code that was rendered would be reimbursed if any of the above conditions apply.	
98971	Qualified nonphysician health care professional online digital assessment and management service, for an established patient, for up to seven days, cumulative time during the seven days; 11–20 minutes	- Cannot take place during an in-person visit. - Cannot take place within seven days after an in-person visit furnished by the same provider. - Cannot trigger an in-person visit within 24	These services do not require prior authorization and are patient-initiated by established patients of the provider's practice.

		hours or the soonest available appointment. - Do not have sufficient information from the remote evaluation of an image or video (store and forward) for the provider to complete the service. Only the relevant in-person procedure code that was rendered would be reimbursed if any of the above conditions apply.	
98972	Qualified nonphysician health care professional online digital assessment and management service, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes	- Cannot take place during an in-person visit. - Cannot take place within seven days after an in-person visit furnished by the same provider. - Cannot	These services do not require prior authorization and are patient-initiated by established patients of the provider's practice.

		trigger an in-person visit within 24 hours or the soonest available appointment. - Do not have sufficient information from the remote evaluation of an image or video (store and forward) for the provider to complete the service. Only the relevant in-person procedure code that was rendered would be reimbursed if any of the above conditions apply.	

* Use 92507 with modifier UC for therapy following a cochlear implant.

** The procedure code description defines this code as one hour. One unit of this code = 1 hour. If less than one hour is used, bill in decimals to the nearest quarter hour. For example, 45 minutes = .75 units and 30 minutes = .5 units. If more than one hour of service is provided, up to one unit of code 92608 can be used in combination with this code.

*** The procedure code description defines this code as 30 minutes. One unit of this code = 30 minutes. If less than 30 minutes is used, bill in decimals to the nearest quarter hour. For example, 15 minutes = .5 units.

Topic #2751

Unit of Service

Some procedure code descriptions do not specify a unit of time. When an amount of time is not specified, the entire service, for each DOS (date of service), equals one unit. For example, descriptions for 94667 (for PT (physical therapy) and OT (occupational therapy) services) and 92612 (for SLP (speech and language pathology) services) do not specify the duration of the service; therefore, one unit indicates the complete service.

Some procedure code descriptions specify a unit of time. When an amount of time is specified, that amount of time equals one unit. For example, the description for 97032 (for PT and OT services) indicates "each 15 minutes;" therefore, 15 minutes are equal to one unit. The description for 92607 (for SLP services) indicates "first hour;" therefore, one hour is equal to one unit.

In addition, part of a unit may be indicated by using a number with a decimal point. For example, in the case of 97140, 7.5 minutes are equal to .5 units. In the case of 92607, 30 minutes are equal to .5 units. (As with Medicare, **SLP** providers may not submit a claim for services provided for less than eight minutes.)

Topic #643

Unlisted Procedure Codes

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

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

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

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

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

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

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

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

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

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

Unlisted Codes That Do Not Require Prior Authorization

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

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

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

How to Submit Claims and Related Documentation

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

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

Topic #830

Valid Codes Required on Claims

ForwardHealth requires that all codes indicated on claims and PA (prior authorization) requests, including diagnosis codes, revenue codes, HCPCS (Healthcare Common Procedure Coding System) codes, HIPPS (Health Insurance Prospective Payment System) codes, and CPT (Current Procedural Terminology) codes be valid codes. Claims received without valid diagnosis codes, revenue codes, and HCPCS, HIPPS, or CPT codes will be denied; PA requests received without valid codes will be 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 (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 (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 #2750

A Comprehensive Overview

Covered PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services are identified by the PT, OT, and SLP procedure codes compiled by BadgerCare Plus.

The DME (durable medical equipment) and DMS (disposable medical supplies) indices may be referenced for DME and DMS that may be provided by PT, OT, and SLP providers.

Providers may refer to the DME and DMS service areas for more information about policy, PA (prior authorization) requirements, and claims submission instruction for DME/DMS services.

Topic #2749

Daily Limitations

For PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) procedure codes that specify the unit of time, Wisconsin Medicaid does not reimburse PT, OT, and SLP providers beyond 90 minutes per day unless additional time is requested and approved through an adjustment request to an allowed claim. Services provided beyond this daily limit generally exceed the medically necessary, reasonable, and appropriate duration of PT, OT, and SLP services.

In addition, the same modality may not be reimbursed as a PT service and an OT service on the same DOS (date of service) for the same member.

Many PT, OT, and SLP services may be provided only a limited number of times per day. Daily service limitations are indicated in the PT, OT, and SLP procedure code lists and in the PT, OT, and SLP Birth to 3 procedure code lists.

Topic #44

Definition of Covered Services

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

Topic #2748

Duplicate Services

Duplicate services may not be reimbursed by Wisconsin Medicaid. Wisconsin Medicaid may deny payment when another provider has a valid PA (prior authorization) for duplicate PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services or when prior payment for duplicate services has been made to another provider.

To avoid potential claim denials resulting from duplicate services, providers are encouraged to request PA when they are unsure

whether the member has received, or is currently receiving, PT, OT, or SLP services from another provider.

Topic #2747

Durable Medical Equipment and Disposable Medical Supplies

Certain DME (durable medical equipment) and DMS (disposable medical supplies) may be provided by PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) providers. As with all covered services, DME and DMS must meet all program requirements, which can be found in the DME or DMS service area.

Note: Most DMS used when providing a service are considered part of the provider's overhead cost and are not separately reimbursable. For example, gloves used during PT, OT, and SLP sessions are not covered.

For DME and DMS that may be provided by PT, OT, and SLP providers, refer to the DME and DMS indices.

Topic #85

Emergencies

Certain program requirements and reimbursement procedures are modified in emergency situations. Emergency services are defined in Wis. Admin. Code § DHS 101.03(52), as those services that are necessary to prevent the death or serious impairment of the health of the individual. Emergency services are not reimbursed unless they are covered services.

Additional definitions and procedures for emergencies exist in other situations, such as dental and mental health.

Program requirements and reimbursement procedures may be modified in the following ways:

- PA (prior authorization) or other program requirements may be waived in emergency situations.
- Non-U.S. citizens may be eligible for covered services in emergency situations.

Topic #2746

Evaluations

For covered services, ForwardHealth accepts a signed and dated physician prescription for evaluation and treatment as the initial order for evaluation and as the initial POC (plans of care) for PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services. The prescription may be written by the physician or by the provider who makes a written record of the physician's verbal order. If the prescription is for evaluation and treatment, both are reimbursable on the initial DOS (date of service) when both are medically necessary.

Note: PA (prior authorization) is not required for reimbursement of OT, PT or SLP evaluations or re-evaluations.

If treatment begins on the same DOS as the evaluation, the providing therapist is required to either write or dictate an initial therapy POC by the close of business the day following the evaluation or by the close of business on the therapist's next scheduled work day. The prescribing physician is required to review, sign, and date the initial therapy POC promptly, but no later than 30 calendar days from the date the initial therapy POC was written or dictated.

If the physician wrote the prescription as "evaluation" or "evaluation only," reimbursement for treatment will not be allowable until

the therapist writes or dictates a therapy POC and the physician reviews, signs, and dates the POC, or until the therapist has received a physician's verbal order to treat that has been reduced to writing. The prescribing physician is required to review, sign, and date the initial therapy POC promptly, but no later than 30 calendar days from the date the initial therapy POC was committed to writing or dictated.

Evaluations are not reimbursed by ForwardHealth when any of the following are true:

- A screening is sufficient.
- Professional skills of a PT, OT, SLP provider are not required to perform the evaluation.
- The evaluation is completed solely because of a change in one of the following:
  - The member's other health insurance coverage
  - The PT, OT, or SLP provider's employment status (for example, business ownership)
- The evaluation is not medically necessary (for example, an evaluation performed for the purpose of vocational training).
- The PT, OT, or SLP provider reports a change in the member's status, but the POC is not updated to reflect this change.

Frequently Asked Questions Regarding Evaluations

ForwardHealth covers evaluations for PT (physical therapy), OT (occupational therapy), and SLP (speech language pathology), when all applicable rules and regulations are met. The following questions and answers are offered to assist providers with information regarding BadgerCare Plus coverage of therapy evaluations:

Q: Does an evaluation need to be completed before submitting a PA (prior authorization) request?

A: Yes. ForwardHealth reviews both the PA request and the written report of the comprehensive evaluation submitted with the PA request to determine if the service is medically necessary. This is an exception to the general rule that PA should be granted before a service is performed.

Q: Does Wisconsin Medicaid pay for screenings?

A: No. Wisconsin Medicaid does not reimburse therapy providers for screening services.

Q: Do ForwardHealth members receiving Birth to 3 Program therapies need a physician prescription?

A: Yes. While the Birth to 3 Program does not require a physician prescription for services including evaluations per DHS 90, ForwardHealth does require a signed and dated physician prescription for evaluation and treatment in order for services provided to ForwardHealth members to be reimbursed.

Topic #2745

Group Therapy

Group therapy may be reimbursed by Wisconsin Medicaid for OT (occupational therapy), PT (physical therapy) and SLP (speech and language pathology) services.

Group Occupational Therapy Services

A group setting for OT may consist of either of the following:

- Up to six patients supervised by one Medicaid-enrolled occupational therapist
- Six to 12 patients supervised by two qualified OT staff members, one of whom is a Medicaid-enrolled occupational therapist

Group Physical Therapy Services

A group setting for PT may consist of either of the following:

- Two-five individuals supervised by one Medicaid-enrolled physical therapist or physical therapist assistant
- Six-10 individuals supervised by two qualified PT staff members, one of whom is a Medicaid-enrolled physical therapist or physical therapist assistant

PT aides may not be reimbursed for group PT services in either group therapy setting.

Documentation Requirements and Clinical Appropriateness

Documentation in each member's medical record should include the DOS for the group session as well as the following:

- The reason group therapy is medically necessary, the most appropriate mode of therapy for the member, and how group therapy will contribute to the member's anticipated progression to individualized goals
- The skilled services that were provided during the group therapy session
- Documentation of the total group therapy session duration in minutes
- Documentation of the number of patients and the number of providers for each group therapy session

The member's POC (plan of care) should offer the most effective and efficient treatment and balance appropriate resources to provide the best possible outcomes. Group therapy sessions should be of sufficient length to address the needs of each of the individuals in the group without requiring direct one-on-one patient contact.

Providers must review ForwardHealth PA (prior authorization) policy regarding PA limits for PT services if there are circumstances that may require PA for any individuals participating in the group therapy session, including SOI (spell of illness) requirements. (Refer to the PA section of the Therapies: Physical, Occupational, and Speech and Language Pathology service area for more information about PA policy for PT services.)

Group Speech and Language Pathology Services

A group setting for SLP may consist of up to four BadgerCare Plus members. SLP group therapy is limited to the areas of expressive language, hearing or auditory training, or receptive language.

Topic #22917

Interpretive Services

ForwardHealth reimburses interpretive services provided to BadgerCare Plus and Medicaid members who are deaf or hard of hearing or who have LEP (limited English proficiency). A member with LEP is someone who does not speak English as their primary language and who has a limited ability to read, speak, write, or understand English.

Interpretive services are defined as the provision of spoken or signed language communication by an interpreter to convey a message from the language of the original speaker into the language of the listener in real time (synchronous) with the member present. This task requires the language interpreter to reflect both the tone and the meaning of the message.

Only services provided by interpreters of the spoken word or sign language will be covered with the HCPCS (Healthcare Common Procedure Coding System) procedure code T1013 (Sign language or oral interpretive services, per 15 minutes). Translation services for written language are not reimbursable with T1013, including services provided by professionals trained to interpret written text.

Covered Interpretive Services

ForwardHealth covers interpretive services for deaf or hard of hearing members or members with LEP when the interpretive service and the medical service are provided to the member on the same DOS (date of service) and during the same time as the medical service. A Medicaid-enrolled provider must submit for interpretive services on the same claim as the medical service, and the DOS they are provided to the member must match. Interpretive services cannot be billed by HMOs and MCOs (managed care organizations). Providers should follow CPT (Current Procedural Terminology) and HCPCS coding guidance to appropriately document and report procedure codes related to interpretive and medical services on the applicable claim form. Time billed for interpretive services should reflect time spent providing interpretation to the member. At least three people must be present for the services to be covered: the provider, the member, and the interpreter.

Interpreters may provide services either in-person or via telehealth. Services provided via telehealth must be functionally equivalent to an in-person visit, meaning that the transmission of information must be of sufficient quality as to be the same level of service as an in-person visit. Transmission of voices, images, data, or video must be clear and understandable. Both the distant and originating sites must have the requisite equipment and staffing necessary to provide the telehealth service.

Billing time for documentation of interpretive services will be considered part of the service performed. BadgerCare Plus and Wisconsin Medicaid have adopted the federal "Documentation Guidelines for Evaluation and Management Services" (CMS (Centers for Medicare & Medicaid Services) 2021 and 2023) in combination with BadgerCare Plus and Medicaid policy for E&M (evaluation and management) Services.

Most Medicaid-enrolled providers, including border-status or out-of-state providers, are able to submit claims for interpretive services.

Standard ForwardHealth policy applies to the reimbursement for interpretive services for out-of-state providers, including PA (prior authorization) requirements.

Interpretive Services Provided Via Telehealth for Out-of-State Providers

ForwardHealth requirements for services provided via telehealth by out-of-state providers are the same as the ForwardHealth policy for services provided in-person by out-of-state providers. Requirements for out-of-state providers for interpretive services are the same whether the service is provided via telehealth or in-person. Out-of-state providers who are not enrolled as either border-status or telehealth-only border-status providers are required to obtain PA before providing services via telehealth to BadgerCare Plus or Medicaid members. The PA would indicate that interpretive services are needed.

Documentation

While not required for submitting a claim for interpretive services, providers must include the following information in the member's file:

- The interpreter's name and/or company
- The date and time of interpretation
- The duration of the interpretive service (time in and time out or total duration)
- The amount submitted by the medical provider for interpretive services reimbursement
- The type of interpretive service provided (foreign language or sign language)
- The type of covered service(s) the provider is billing for

Third-Party Vendors and In-House Interpreters

Providers may be reimbursed for the use of third-party vendors or in-house interpreters supplying interpretive services.

Providers are reminded that HIPAA (Health Insurance Portability and Accountability Act of 1996) confidentiality requirements

apply to interpretive services. When a covered entity or provider utilizes interpretive services that involve PHI (protected health information), the entity or provider will need to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to PHI confidentiality, integrity, and availability. Each entity or provider must assess what are reasonable and appropriate measures for their situation.

Limitations

There are no limitations for how often members may utilize interpretive services when the interpretive service is tied to another billable medical service for the member for the same DOS.

Claims Submission

To receive reimbursement, providers may bill for interpretive services on one of the following claim forms:

- 1500 Health Insurance Claim Form ((02/12)) (for dental, professional, and professional crossover claims)
- Institutional UB-04 (CMS 1450) claim form (for outpatient crossover claims and home health/personal care claims)

Noncovered Services

The following will not be eligible for reimbursement with procedure code T1013:

- Interpretive services provided in conjunction with a noncovered, non-reimbursable, or excluded service
- Interpretive services provided by the member's family member, such as a parent, spouse, sibling, or child
- The interpreter's waiting time and transportation costs, including travel time and mileage reimbursement, for interpreters to get to or from appointments
- The technology and equipment needed to conduct interpretive services
- Interpretive services provided directly by the HMOs and MCOs are not billable to ForwardHealth for reimbursement via procedure code T1013

Cancellations or No Shows

Providers cannot submit a claim for interpretive services if an appointment is cancelled, the member or the interpreter is a no-show (is not present), or the interpreter is unable to perform the interpretation needed to complete the appointment successfully.

Procedure Code and Modifiers

Providers must submit claims for interpretive services and the medical service provided to the member on separate details on the same claim.

Procedure code T1013 is a time-based code, with 15-minute increments. Rounding up to the 15-minute mark is allowable if at least eight minutes of interpretation were provided.

Providers should use the following rounding guidelines for procedure code T1013.

Time (Minutes)	Number of Interpretation Units Billed
8–22 minutes	1.0 unit
23–37 minutes	2.0 units
38–52 minutes	3.0 units
53–67 minutes	4.0 units
68–82 minutes	5.0 units

83–97 minutes	6.0 units

Claims for interpretive services must include HCPCS procedure code T1013 and the appropriate modifier(s):

- U1 (Spoken language)
- U3 (Sign Language)
- GT (Via interactive audio and video telecommunication systems)
- 93 (Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system)

Providers should refer to the interactive maximum allowable fee schedules for the reimbursement rate, covered provider types and specialties, modifiers, and the allowable POS (place of service) codes for procedure code T1013.

Delivery Method of Interpretive Services	Definition for Sign Language and Foreign Language Interpreters		Modifiers
In person (foreign language and sign language)	When the interpreter is physically present with the member and provider		U1 or U3
Telehealth* (foreign language and sign language)	When the member is located at an originating site and the interpreter is available remotely (via audio-visual or audio only) at a distant site		U1 or U3 **and** GT or 93
	Phone (foreign language only)	When the interpreter is not physically present with the member and the provider and interprets via audio-only through the phone	U1 **and** 93
	Interactive video (foreign language and sign language)	When the interpreter is not physically present with the member and the provider and interprets on interactive video	U1 or U3 **and** GT

*Any telehealth service must be provided using HIPAA-compliant software or delivered via an app or service that includes all the necessary privacy and security safeguards to meet the requirements of HIPAA.

Dental Providers

Dental providers submitting claims for interpretive services are not required to include a modifier with procedure code T1013. Dental providers should retain documentation of the interpretive service in the member's records.

Allowable Places of Service

Claims for interpretive services must include a valid POS (place of service) code where the interpretive services are being provided.

Federally Qualified Health Centers

Non-tribal FQHCs (federally qualified health centers), also known as CHCs (community health centers), (POS code 50), will not

receive direct reimbursement for interpretive services as these are indirect services assumed to be already included in the FQHC's bundled PPS (prospective payment system) rate. However, CHCs can still bill the T1013 code as an indirect procedure code when providing interpretive services. This billing process is similar to that of other indirect services provided by non-tribal FQHCs. This will enable DHS (Wisconsin Department of Health Services) to better track how FQHCs provide these services and process any future change in scope adjustment to increase their PPS rate that includes providing interpretive services.

Rural Health Clinics

RHCs (rural health clinics) (POS code 72) receives direct reimbursement for interpretive services. Procedure code T1013 should be billed when providing interpretive services.

Interpreter Qualifications

The two types of allowable interpreters include:

- Sign language interpreters—Professionals who facilitate the communication between a hearing individual and a person who is deaf or hard of hearing and uses sign language to communicate
- Foreign language interpreters—Professionals who are fluent in both English and another language and listen to a communication in one language and convert it to another language while retaining the same meaning.

Qualifications for Sign Language Interpreters

For Medicaid-enrolled providers to receive reimbursement, sign language interpreters must be licensed in Wisconsin under Wis. Stat. § 440.032 and must follow the specific requirements regarding education, training, and locations where they are able to interpret. The billing provider is responsible for determining the sign language interpreter's licensure and must retain all documentation supporting it.

Qualifications for Foreign Language Interpreters

There is not a licensing process in Wisconsin for foreign language interpreters. However, Wisconsin Medicaid strongly recommends that providers work through professional agencies that can verify the qualifications and skills of their foreign language interpreters.

A competent foreign language interpreter should:

- Be at least 18 years of age.
- Be able to interpret effectively, accurately, and impartially, both receptively and expressively, using necessary specialized vocabulary.
- Demonstrate proficiency in English and another language and have knowledge of the relevant specialized terms and concepts in both languages.
- Be guided by the standards developed by the National Council on Interpreting Health Care.
- Demonstrate cultural responsiveness regarding the LEP language group being served including values, beliefs, practices, languages, and terminology.

Topic #84

Medical Necessity

Wisconsin Medicaid reimburses only for services that are medically necessary as defined under Wis. Admin. Code § DHS 101.03(96m). Wisconsin Medicaid may deny or recoup payment if a service fails to meet Medicaid medical necessity requirements.

Topic #86

Member Payment for Covered Services

Under state and federal laws, a Medicaid-enrolled provider may not collect payment from a member, or authorized person acting on behalf of the member, for covered services even if the services are covered but do not meet program requirements. Denial of a claim by ForwardHealth does not necessarily render a member liable. However, a covered service for which PA (prior authorization) was denied is treated as a noncovered service. (If a member chooses to receive an originally requested service instead of the service approved on a modified PA request, it is also treated as a noncovered service.) If a member requests a covered service for which PA was denied (or modified), the provider may collect payment from the member if certain conditions are met.

If a provider collects payment from a member, or an authorized person acting on behalf of the member, for a covered service, the provider may be subject to program sanctions including termination of Medicaid enrollment.

Topic #66

Program Requirements

For a covered service to meet program requirements, the service must be provided by a qualified Medicaid-enrolled provider to an enrolled member. In addition, the service must meet all applicable program requirements, including—but not limited to—medical necessity, PA (prior authorization), claims submission, prescription, and documentation requirements.

Topic #2742

To receive Medicaid reimbursement for a covered service, all Medicaid requirements must be met. For PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services, the following statements must be true:

- Professional skills of a PT, OT, or SLP provider are required to meet the member's therapy treatment needs.
- Services are cost-effective when compared with other services that meet the member's needs.
- Services are established in a written POC (plan of care) before they are provided.
- Services are medically necessary as defined under Wis. Admin. Code § DHS 101.03(96m).
- Services are performed by a Medicaid-enrolled provider and supervision requirements are met.
- Services are prescribed by a physician.
- Services are prior authorized by ForwardHealth, when applicable.

Topic #21278

Requesting Services for Members Under Age 21

ForwardHealth covers community-based OT (occupational therapy), PT (physical therapy), and SLP (speech and language pathology) services provided to members under the age of 21 when the primary objective for treatment is to support the member's home- and community-based needs.

For members aged 0–3 years, ForwardHealth does not consider community-based OT, PT, and SLP to be duplicative of services received through the Birth to 3 Program. Members in the 0–3 age range may require services through both the Birth to 3 Program and through the outpatient therapy setting out of medical necessity. Participation in OT, PT, and SLP services in one setting is not intended to replace services in the other setting.

Topic #20218

Serial Casting

ForwardHealth allows an OT (occupational therapist) or PT (physical therapist) to bill for serial casting using general casting and casting supply codes. Serial casting is the process of repeated application of casts at a joint for the purpose of increasing range of motion. A list of allowable physical therapy and occupational therapy procedure codes including allowable general casting and casting supply codes is available.

Serial casting does not include the application of a cast, or subsequent casts, to immobilize a joint following fracture, injury, or surgery. Claims will be denied for general casting codes and casting supply codes submitted by OTs or PTs, as a rendering provider, for the purpose of immobilizing a joint following a fracture, injury or surgery.

Reimbursement

ForwardHealth's reimbursement for general casting codes includes evaluation time, fitting time, and follow-up time. Cast materials are reimbursable when billed separately with the appropriate HCPCS (Healthcare Common Procedure Coding System) procedure code(s).

Prior Authorization

After the first 35 visits covered by the initial SOI (spell of illness), PA (prior authorization) is required.

Claim Submission

OTs and PTs are required to submit a professional claim for serial casting using the appropriate CPT (Current Procedural Terminology) general casting and HCPCS casting supply procedure code(s).

Required Modifiers

Providers are required to use the following modifiers with the appropriate CPT general casting procedure code(s) and HCPCS casting supply code(s) for claims and PA requests:

- GO (Services delivered under an outpatient occupational therapy plan of care)
- GP (Services delivered under an outpatient physical therapist plan of care)

Diagnosis Codes

ICD-10 (International Classification of Diseases, 10th Revision) diagnosis codes related to a condition that requires the repeated application of casts at a joint for the purpose of increasing range of motion are allowable for serial casting claims. ForwardHealth does not cover serial casting for the treatment of fractures; therefore, diagnosis codes related to immobilizing a joint following a fracture, injury, or surgery (diagnosis code range including but not limited to S00.00-T88.9) are not reimbursable for serial casting performed by an OT or PT.

Topic #824

Services That Do Not Meet Program Requirements

As stated in Wis. Admin. Code § DHS 107.02(2), BadgerCare Plus and Wisconsin Medicaid may deny or recoup payment for

covered services that fail to meet program requirements.

Examples of covered services that do not meet program requirements include the following:

- Services for which records or other documentation were not prepared or maintained
- Services for which the provider fails to meet any or all of the requirements of Wis. Admin. Code § DHS 106.03, including, but not limited to, the requirements regarding timely submission of claims
- Services that fail to comply with requirements or state and federal statutes, rules, and regulations
- Services that Wisconsin DHS (Department of Health Services), the PRO (Peer Review Organization) review process, or BadgerCare Plus determines to be inappropriate, in excess of accepted standards of reasonableness or less costly alternative services, or of excessive frequency or duration
- Services provided by a provider who fails or refuses to meet and maintain any of the enrollment requirements under Wis. Admin. Code ch. DHS 105
- Services provided by a provider who fails or refuses to provide access to records
- Services provided inconsistent with an intermediate sanction or sanctions imposed by DHS

Topic #2744

Spell of Illness Policy Basics

An SOI (spell of illness) begins with the first day of evaluation or treatment and ends when the services are no longer required or after the allowable DOS (dates of service) have been used, whichever comes first. The allowable DOS include any treatments covered by other health insurance sources or any treatments provided by another provider in any setting except for PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services provided in schools, which do not count toward the initial SOI under Wisconsin Medicaid and BadgerCare Plus.

Per Wis. Admin. Code § DHS 107.16(2)(c), DHS 107.17(2)(c), and DHS 107.18(2)(c), the following conditions may justify an SOI:

- An acute onset of a new disease, injury, or condition such as neuromuscular dysfunction, including stroke-hemiparesis, MS (multiple sclerosis), Parkinson's disease, and diabetic neuropathy
- An acute onset of a new disease, injury, or condition such as musculoskeletal dysfunction, including fracture, amputation, strains and sprains, and complications associated with surgical procedures
- An acute onset of a new disease, injury, or condition such as problems and complications associated with physiological dysfunction, including severe pain, vascular conditions, and cardio-pulmonary conditions
- An exacerbation of a pre-existing condition including, but not limited to, MS, RA (rheumatoid arthritis), or Parkinson's disease
- A regression in the member's condition due to a lack of therapy, as indicated by a decrease of functional ability, strength, mobility, or motion

Providers are reminded that "a regression in the member's condition" relates to a regression in the member's ability to participate in functional activities that he/she is typically able to perform due to a "lack of" therapy services, as indicated by "a decrease of strength, mobility, or motion" (or an impairment that requires the skills of a therapist to treat).

Initial Spell of Illness

Up to 35 DOS are allowed for each therapy discipline the first time a member requires PT, OT, or SLP services in his or her lifetime. This is called the member's **initial** SOI. The member's initial SOI does not require PA (prior authorization). However, some services always require PA, even when they are provided during a member's initial SOI.

The initial SOI begins with the first day of evaluation or treatment and ends when the services are no longer required or after the 35 DOS, whichever comes first. The 35 DOS include any treatments covered by other health insurance sources. If after 35 DOS

the member's condition requires additional PT, OT, or SLP services, PA is required.

To receive Medicaid reimbursement, PT, OT, and SLP services provided within the initial 35 DOS must meet the same medical necessity requirements as PT, OT, and SLP services that require PA.

Therapy services provided as SBS (school-based services) do not count against the allowable number of DOS.

Subsequent Spells of Illness

After the initial SOI, any new disease, injury, medical condition, or increased severity of a pre-existing medical condition that requires PT, OT, or SLP services is called a subsequent SOI. A subsequent SOI always requires PA. When approved, the PA for a subsequent SOI is granted with 20 DOS to be used over six months between the grant and end dates.

Unused Dates of Service

Unused DOS from one SOI cannot be carried over into a new SOI. When a new, approved SOI occurs during an existing SOI, the current SOI ends, and a new one begins.

New Spells of Illness

If a member who is being treated under an existing SOI requires treatment for a new disease, injury, or medical condition, a new PA request to treat both conditions must be submitted. In this situation, providers are required to:

- Enddate the existing SOI PA using the Prior Authorization Amendment Request (F-11042 (07/2012)).

  AND

- Submit a new SOI PA request using the PA/SOIA (Prior Authorization/Spell of Illness Attachment, F-11039 (10/2015)) form to treat both conditions if the new condition meets the requirements for SOI.

  OR

- Submit a new therapy PA request using the PA/TA (Prior Authorization/Therapy Attachment, F-11008 (04/2025)) to treat both conditions if the new condition does not meet the requirements for SOI.

Providers are reminded claims cannot be submitted for DOS for the new disease, injury, or medical condition until the new PA request has been approved.

Services unrelated to the condition under which the SOI was approved may not be billed under the approved PA request for that SOI and require a separate PA request.

Home Health Equipment

Topic #1747

Speech Generating Devices, Synthesized

Purchase, rental, and repair of dedicated synthesized SGDs (Speech Generating Device) are covered when PA (Prior Authorization) criteria are met. The device must improve a member's communication ability when alternative natural communication methods are not feasible or are inadequate for their daily functional communication.

ForwardHealth recommends that members undergo an up to 90 day trial period with the synthesized SGD before a PA request for purchase is submitted. This trial period is not required prior to submitting a PA for the purchase; however, the trial period allows the member to demonstrate progress related to targeted SGD communication skills during and outside of treatment sessions and within targeted interactions (for example, with a caregiver or other team members). Documented progress during the trial period can help substantiate the medical necessity of the SGD purchase request.

Note: In limited circumstances, such as a member with amyotrophic lateral sclerosis, if the member demonstrated proficiency with the device at the end of the initial evaluation, the provider should consider submission of a PA to purchase the SGD without further trial of the device or additional therapy data.

Accessories

The following accessories are included in the purchase of a SGD, and are not separately reimbursable at the time of initial purchase:

- AC adapters
- All applicable software programs
- Batteries
- Battery chargers
- Nonintegrated keyboards
- Protective case or covers

Telehealth

Topic #22617

Birth to 3 Telehealth Services

ForwardHealth reimburses therapy providers supplying services as part of the Birth to 3 Program at an enhanced rate when occupational therapy, physical therapy, and/or speech therapy is performed using telehealth and the member is located in their natural environment as defined in both 34 C.F.R. Part 303 and Wis. Admin. Code § DHS 90.03(25).

To receive this reimbursement, therapy providers must meet all other requirements and indicate the following modifier types when submitting a claim:

- Therapy type modifier: GN (Services delivered under an outpatient speech language pathology plan of care), GO (Services delivered under an outpatient occupational therapy plan of care), or GP (Services delivered under an outpatient physical therapy plan of care)
- Birth to 3 enhanced rate modifier: TL (Early IFSP (intervention/individualized family service plan))
- Telehealth modifier: GQ, GT, FQ, or 93

Therapy providers must also indicate the POS (place of service) where the therapy is performed. Allowable POS codes are as follows:

- 02 (Telehealth Provided Other than in Patient's Home)
- 04 (Homeless Shelter)
- 10 (Telehealth Provided in Patient's Home)
- 12 (Home)
- 99 (Other Place of Service)

Topic #22739

Originating and Distant Sites

The originating site is where the member is located during a telehealth visit. Only the provider at the originating site can bill for an originating site fee for hosting the member. The originating site should not use telehealth modifiers on the claims since all services are provided in-person. The distant site is where the provider is located during the telehealth visit. The provider who is providing health care services to the member via telehealth cannot bill the originating site fee because they are not hosting the member.

The following locations are eligible for the originating site fee under permanent telehealth policy:

- Office or clinic:
  - Medical
  - Dental
  - Therapies (physical therapy, occupational therapy, speech and language pathology)
  - Behavioral and mental health agencies
- Hospital
- Skilled nursing facility
- Community mental health center
- Intermediate care facility for individuals with intellectual disabilities

- Pharmacy
- Day treatment facility
- Residential substance use disorder treatment facility

Claims Submission and Reimbursement for Distant Site Providers

Claims for services provided via telehealth by distant site providers must be billed with the same procedure code as would be used for a face-to-face encounter along with modifiers GQ, GT, FQ, or 93.

Note: Only the service rendered from the distant site must be billed with modifier GQ. The originating site for asynchronous services is not eligible to receive an originating site fee.

Claims must also include either POS (place of service) code 02 or 10. ForwardHealth reimburses the service rendered by distant site providers at the same rate as when the service is provided face-to-face.

Ancillary Providers

Claims for services provided via telehealth by distant site ancillary providers should continue to be submitted under the supervising physician's NPI (National Provider Identifier) using the lowest appropriate level office or outpatient visit procedure code or other appropriate CPT (Current Procedural Terminology) code for the service performed. These services must be provided under the direct on-site supervision of a physician who is located at the same physical site as the ancillary provider and must be documented in the same manner as services that are provided face to face.

Refer to the Supervision topic for additional information.

Pediatric and Health Professional Shortage Area-Eligible Services

Claims for services provided via telehealth by distant site providers may additionally qualify for pediatric (services for members 18 years of age and under) or HPSA (Health Professional Shortage Area)-enhanced reimbursement. Pediatric and HPSA-eligible providers are required to indicate POS code 02 or 10, along with modifier GQ, GT, FQ, or 93 and the applicable pediatric or HPSA modifier, when submitting claims that qualify for enhanced reimbursement.

Claims Submission and Reimbursement for Originating Site Fee

In addition to reimbursement to the distant site provider, ForwardHealth reimburses an originating site fee for the staff and equipment at the originating site requisite to provide a service via telehealth. Eligible providers who serve as the originating site should bill the fee with HCPCS procedure code Q3014 (Telehealth originating site fee). Modifier GQ, GT, FQ, or 93 should not be included with procedure code Q3014.

Outpatient hospitals, including emergency departments, must bill HCPCS procedure code Q3014 on an institutional claim form as a separate line item with revenue code 0780. ForwardHealth will reimburse hospitals for the fee based on the standard hospital reimbursement methodology. ForwardHealth will reimburse these providers for the fee based on the provider's standard reimbursement methodology.

All other providers should bill HCPCS procedure code Q3014 with a POS code that represents where the member is located during the service. The POS must be a ForwardHealth-allowable originating site for HCPCS procedure code Q3014 in order to be reimbursed for the originating site fee. Billing-only provider types must include an allowable rendering provider on the claim form. The originating site fee is reimbursed based on a maximum allowable fee.

Although FQHCs are not directly reimbursed an originating site fee, HCPCS procedure code Q3014 should be billed for tracking purposes and for consideration in any potential future changes in scope.

To receive reimbursement, the originating site must:

- Utilize an interactive audiovisual telecommunications system that permits real-time communication between the provider at the distant site and the member at the originating site.
- Be in a physical location that ensures privacy.
- Provide access to broadband internet with sufficient bandwidth to transmit audio and video data.
- Provide access to support staff to assist with technical components of the telehealth visit.
- Be compliant with Health Insurance Portability and Accountability Act of 1996 standards.

Federally Qualified Health Centers and Rural Health Clinics

For the purpose of this Online Handbook topic, FQHC (Federally Qualified Health Center) refers to Tribal and Out-of-State FQHCs. This topic does not apply to Community Health Centers subject to PPS (prospective payment system) reimbursement.

FQHCs and RHCs (rural health clinics) may serve as originating site and distant site providers for telehealth services.

Distant Site

FQHCs and RHCs may report services provided via telehealth on the cost settlement report when the FQHC or RHC served as the distant site and the member is an established patient of the FQHC or RHC at the time of the telehealth service. For currently covered services, services that are considered direct when provided in-person will be considered direct when provided via telehealth for FQHCs.

Services billed with modifier GQ, GT, FQ, or 93 will be considered under the PPS (prospective payment system) reimbursement method for non-tribal FQHCs. Billing HCPCS procedure code T1015 (Clinic visit/encounter, all-inclusive) with a telehealth procedure code will result in a PPS rate for fee-for-service encounters. Fee-for-service claims must include HCPCS procedure code T1015 when services are provided via telehealth in order for proper reimbursement.

Originating Site

The originating site fee is not a FQHC or RHC reportable encounter on the cost report. Any reimbursement for the originating site fee must be reported as a deductive value on the cost report.

Topic #22757

Supervision

Supervision requirements and respective telehealth allowances vary depending on service and provider type. Some supervision requirements necessitate the physical presence of the supervising provider to meet the requirements of appropriate delivery of supervision. Such requirements cannot be met through the provision of telehealth, including audio-visual delivery.

Providers who deliver services with supervision requirements are reminded to review ForwardHealth policy, including permanent telehealth policy, and the requirements of their licensing and/or certifying authorities to determine if the supervisory components of the service can be met via telehealth.

Supervision of Paraprofessional Providers

Paraprofessional providers are subject to supervision requirements. Paraprofessional providers are providers who do not hold a license to practice independently but are providing services under the direction of a licensed provider. Providers who supervise paraprofessionals are responsible for confirming if the required components of supervision can be met through telehealth delivery.

Personal Care/Home Health Provider Supervision

Supervision of PCWs (personal care workers) and home health aides must be performed on site and in person by the RN (registered nurse). State rules and regulations necessitate supervising providers to physically visit a member's home and directly observe the paraprofessional providing services.

Direct Supervision for Ancillary Care Providers

Ancillary providers have specific requirements when providing care via telehealth. These providers are health care professionals that are not enrolled in Wisconsin Medicaid, such as staff nurses, dietician counselors, nutritionists, health educators, genetic counselors, and some nurse practitioners who practice under the direct supervision of a physician and bill under the supervising physician's NPI (National Provider Identifier). (Nurse practitioners, nurse midwives, and anesthetists who are Medicaid-enrolled should refer to their service-specific area of the Online Handbook for billing information).

For telehealth services, the supervising physician is not required to be onsite, but they must be able to interact with the member using real-time audio or audiovisual communication, if needed. For supervision of ancillary providers, remote supervision is allowed in circumstances where the physician feels the member is not at risk of an adverse event that would require hands-on intervention from the physician.

Supervision for Behavioral Health Services

The FR modifier should be used for behavioral health services where the supervising provider is present through audio-visual means and the patient and supervised provider are in-person.

Documenting Supervision Method

Providers should include how the service and the required supervision occurred in the member record and, if applicable, indicate the appropriate modifier on the claim form. For example, for a behavioral health service where the supervising provider is present through audio-visual means and the patient and supervised provider are in-person, modifier FR should be indicated on the claim.

Topic #22837

Telehealth Definitions

General Telehealth Definitions

Telehealth means the use of telecommunications technology by a Medicaid-enrolled provider to deliver functionally equivalent health care services including: assessment, diagnosis, consultation, treatment, and transfer of medically relevant data. Telehealth may include real-time interactive audio-only communication. Telehealth does not include communication between a provider and a member that consists solely of an email, text, or fax transmission.

Synchronous telehealth services are two-way, real-time, interactive communications. They may include audio-only (telephone) or audio-visual communications.

Asynchronous telehealth services are defined as telehealth that is used to transmit medical data about a patient to a provider when the transmission is not a two-way, real-time, interactive communication.

Functionally equivalent means that when a service is provided via telehealth, the transmission of information must be of sufficient quality as to be the same level of service as an in-person visit. Transmission of voices, images, data, or video must be clear and understandable.

Telehealth Service Definitions

The following are definitions to clarify the meaning of existing terms that describe different modes of telehealth service delivery in telehealth policy.

In-person refers to when the provider rendering a service and the member receiving that service are located together physically in the same space. In-person services are not considered to be delivered through telehealth, including audio-visual telehealth, unless there are applicable supervision components and requirements that are rendered through telehealth outside of the direct patient contact by the provider.

Face-to-face refers to requirements that can be met either in-person or through real-time, interactive audio-visual telehealth. An interactive telehealth service with face-to-face components must be functionally equivalent to an in-person service. It is delivered from outside the physical presence of a Medicaid member by using audio-visual technology, and there is no reduction in quality, safety, or effectiveness. ForwardHealth does not consider a face-to-face requirement to be met by audio-only or asynchronous delivery of services.

Under telehealth policy, **direct** refers to an in-person contact between a member and a provider. Direct services often require a provider to physically touch or examine the recipient and delegation is not appropriate.

Topic #510

Telehealth Policy

Both synchronous (two-way, real-time, interactive communications) and asynchronous (information stored and forwarded to a provider for later review) services identified under permanent policy may be reimbursed when provided via telehealth (also known as telemedicine). ForwardHealth will require providers to follow permanent billing guidelines for both synchronous and asynchronous telehealth services.

Telehealth enables a provider who is located at a distant site to render the service remotely to a member located at an originating site using a combination of interactive video, audio, and externally acquired images through a networking environment.

Telehealth means the use of telecommunications technology by a Medicaid-enrolled provider to deliver functionally equivalent health care services including assessment, diagnosis, consultation, treatment, and transfer of medically relevant data. Telehealth may include real-time interactive audio-only communication. Telehealth does not include communication between a provider and a member that consists solely of an email, text, or fax transmission.

Functionally equivalent means that when a service is provided via telehealth, the transmission of information must be of sufficient quality as to be the same level of service as an in-person visit. Transmission of voices, images, data, or video must be clear and understandable.

Note: Temporary telehealth policy that will become permanent policy shortly after the Federal Health Emergency expires is included in this topic.

Telehealth Policy Requirements

The following requirements apply to the use of telehealth:

- Both the member and the provider of the health care service must agree to the service being performed via telehealth. If either the member or provider decline the use of telehealth for any reason, the service should be performed in-person.
- The member retains the option to refuse the delivery of health care services via telehealth at any time without affecting their right to future care or treatment and without risking the loss or withdrawal of any program benefits to which they would

otherwise be entitled.
- Medicaid-enrolled providers must be able and willing to refer members to another provider if necessary, such as when telehealth services are not appropriate or cannot be functionally equivalent, or the member declines a telehealth visit.
- Title VI of the Civil Rights Act of 1964 requires recipients of federal financial assistance to take reasonable steps to make their programs, services, and activities accessible by eligible persons with limited English proficiency.
- The Americans with Disabilities Act requires that health care entities provide full and equal access for people with disabilities.

Allowable Services

The Max Fee Schedules include a complete list of services allowed under permanent telehealth policy. Procedure codes for services allowed under permanent telehealth policy have POS codes 02 and 10 listed as an allowable POS in the fee schedule. Complete descriptions of these POS codes are as follows:

- POS code 02: Telehealth Provided Other Than in Patient's Home–The location where health services and health related services are provided or received through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.
- POS code 10: Telehealth Provided in Patient's Home–The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.

Claims for services delivered via telehealth must include all modifiers required by the existing benefit coverage policy in order to reimburse the claim correctly. Telehealth delivery of the service is shown on the claim by indicating POS code 02 or 10 and including a telehealth modifier in addition to any other required benefit-specific modifiers, unless the procedure code includes the method of delivery in the official procedure code description.

County-administered programs, school-based services, and any other programs that utilize cost reporting must include required modifiers, such as renderer credentials and group versus individual services, as well as correct details for cost reporting to ensure correct reimbursement.

Services Not Appropriate Via Telehealth

Certain types of benefits or services that are not appropriately delivered via telehealth include:

- Services that are not covered when provided in-person.
- Services that do not meet applicable laws, regulations, licensure requirements, or procedure code definitions if delivered via telehealth.
- Services where a provider is required to physically touch or examine the recipient and delegation is not appropriate.
- Services the provider declines to deliver via telehealth.
- Services the recipient declines to receive via telehealth.
- Transportation services.
- Services provided by personal care workers, home health aides, private duty nurses, or school-based service care attendants.

Reimbursement for Covered Services

The health care provider at the distant site must determine:

- The service delivered via telehealth meets the procedural definition and components of the CPT or HCPCS procedure code, as defined by the American Medical Association, or the CDT (Current Dental Terminology) procedure code, as defined by the American Dental Association.

- The service is functionally equivalent to an in-person service for the individual member and circumstances.

Reimbursement is not available for services that cannot be provided via telehealth due to technical or equipment limitations.

Documentation Requirements

Documentation requirements for a telehealth service are the same as for an in-person visit and must accurately reflect the service rendered. Documentation must identify the delivery mode of the service when provided via telehealth and document:

- Whether the service was provided via audio-visual telehealth, audio-only telehealth, or via telehealth externally acquired images
- Whether the service was provided synchronously or asynchronously

Additional information for which documentation is recommended, but not required, includes:

- Provider location (for example, clinic [city/name], home, other)
- Member location (for example, clinic [city/name], home)
- All clinical participants, as well as their roles and actions during the encounter (This could apply if, for example, a member presents at a clinic and receives telehealth services from a provider at a different location.)

As a reminder, documentation for originating sites must support the member's presence in order to submit a claim for the originating site fee. In addition, if the originating site provides and bills for services in addition to the originating site fee, documentation in the member's medical record should distinguish between the unique services provided.

Audio-Only Guidelines

When possible, telehealth services should include both an audio and visual component. In circumstances where audio-visual telehealth is not possible due to member preference or technology limitations, telehealth may include real-time interactive audio-only communication if the provider feels the service is functionally equivalent to the in-person service and there are no face-to-face or in-person restrictions listed in the procedural definition of the service.

Documentation should include that the service was provided via interactive synchronous audio-only telehealth.

Modifier 93 should be used for any service performed via audio-only telehealth. The GT modifier should only be used to indicate services that were performed using audio-visual technology.

Member Consent Guidelines for Telehealth

On at least an annual basis, providers should supply and document that:

- The member expressed an understanding of their right to decline services provided via telehealth.
- Providers should develop and implement their own methods of informed consent to verify that a member agrees to receive services via telehealth. These methods must comply with all federal and state regulations and guidelines.
- Providers have flexibility in determining the most appropriate method to capture member consent for telehealth services. Examples of allowable methods include educating the member and obtaining verbal consent prior to the start of treatment or telehealth consent and privacy considerations as part of the notice of privacy practices.

Privacy and Security

Providers are required to follow federal laws to ensure member privacy and security. This may include ensuring that:

- The location from which the service is delivered via telehealth protects privacy and confidentiality of member information

and communications.
- The platforms used to connect to the member to the telehealth visit are secure.

Group Treatment

Additional privacy considerations apply to members participating in group treatment via telehealth. Group leaders should provide members with information on the risks, benefits, and limits to confidentiality related to group telehealth and document the member's consent prior to the first session. Group leaders should adhere to and uphold the highest privacy standards possible for the group.

Group members should be instructed to respect the privacy of others by not disclosing group members' images, names, screenshots, identifying details, or circumstances. Group members should also be reminded to prevent non-group members from seeing or overhearing telehealth sessions.

Providers may not compel members to participate in telehealth-based group treatment and should make alternative services available for members who elect not to participate in telehealth-based group treatment.

Costs Member Cannot Be Billed For

The following cannot be billed to the member:

- Telehealth equipment like tablets or smart devices
- Charges for mailing or delivery of telehealth equipment
- Charges for shipping and handling of:
  - Diagnostic tools
  - Equipment to allow the provider to assess, diagnose, repair, or set up medical supplies online such as hearing aids, cochlear implants, power wheelchairs, or other equipment

Allowable Providers

There are no limitations on what provider types may be reimbursed for telehealth services.

Requirements and Restrictions

Services provided via telehealth must be of sufficient audio and visual fidelity and clarity as to be functionally equivalent to a face-to-face visit where both the rendering provider and member are in the same physical location. Both the distant and originating sites must have the requisite equipment and staffing necessary to provide the telehealth service.

Coverage of a service provided via telehealth is subject to the same restrictions as when the service is provided face to face (for example, allowable providers, multiple service limitations, PA (prior authorization)).

Providers are reminded that HIPAA (Health Insurance Portability and Accountability Act of 1996) confidentiality requirements apply to telehealth services. When a covered entity or provider utilizes a telehealth service that involves PHI (protected health information), the entity or provider will need to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to PHI confidentiality, integrity, and availability. Each entity or provider must assess what are reasonable and appropriate security measures for their situation.

Note: Providers may not require the use of telehealth as a condition of treating a member. Providers must develop and implement their own methods of informed consent to verify that a member agrees to receive services via telehealth. These methods must comply with all federal and state regulations and guidelines.

Noncovered Services

Services that are not covered when delivered in person are not covered as telehealth services. In addition, services that are not functionally equivalent to the in-person service when provided via telehealth are not covered.

Additional Policy for Certain Types of Providers

Out-of-State Providers

ForwardHealth policy for services provided via telehealth by out-of-state providers is the same as ForwardHealth policy for services provided face to face by out-of-state providers.

Out-of-state providers who meet the definition of a border-status provider as described in Wis. Admin. Code § DHS 101.03(19) and who provide services to Wisconsin Medicaid members only via telehealth, may apply for enrollment as Wisconsin telehealth-only border-status providers if they are licensed in Wisconsin under applicable Wisconsin statute and administrative code.

Out-of-state providers who do not have border status enrollment with Wisconsin Medicaid are required to obtain PA before providing services via telehealth to BadgerCare Plus or Medicaid members.

Note: Wisconsin Medicaid is prohibited from paying providers located outside of the United States and its territories, including the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

Topic #22742

Virtual Check-In, E-Visit, and Telemedicine Evaluation and Management Services

ForwardHealth includes virtual check-in and e-visit options for members to connect with their providers remotely.

A **virtual check-in** is a brief patient-initiated asynchronous or synchronous communication and technology-based service intended to be used to decide whether an office visit or other service is needed. The encounter may involve synchronous discussion over a phone or exchange of information through video or image. A provider may respond to the member's concern by phone, audio-visual communications, or a secure patient portal. Covered services include both the remote evaluation of a recorded video or image submitted by a member and the interpretation and follow-up by the provider.

An **e-visit** is a communication between a member and their provider through an online HIPAA (Health Insurance Portability and Accountability Act of 1996)-compliant patient portal. These patient-initiated asynchronous services involve a member having non-face-to-face communications cumulatively over a span of seven days with a provider with whom they have an established relationship. Providers who can bill E&M (evaluation and management) services may utilize online digital E&M codes while other providers may be eligible to bill online assessment and management codes.

Allowable procedure codes for virtual check-in and e-visit services:

Virtual Check-In Procedure Code	Description
Physician Services	
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (eg, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E&M service provided within the previous seven days nor leading to an E&M service or procedure

	within the next 24 hours or soonest available appointment
G2252	Brief communication technology-based service (eg, virtual check-in), by a physician or other qualified health care professional who can report Evaluation and Management services, provided to an established patient, not originating from a related E&M service provided within the previous seven days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 11–20 minutes of medical discussion
Therapies (PT, OT, SLP) Services	
G2250	Remote assessment of recorded video and/or images submitted by an established patient (eg, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous seven days nor leading to a service or procedure within the next 24 hours or soonest available appointment
G2251	Brief communication technology-based service (eg, virtual check-in), by a qualified health care professional who cannot report Evaluation and Management services, provided to an established patient, not originating from a related service provided within the previous seven days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of clinical discussion

E-Visit Procedure Code	Description
Therapies (PT, OT, SLP) Services	
98970	Nonphysician qualified health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
98971	Nonphysician qualified health care professional online digital assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11–20 minutes
98972	Nonphysician qualified health care professional online digital assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
Physician Services	
99421	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; 5–10 minutes
99422	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; 11–20 minutes
99423	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes

These services do not require prior authorization and are patient-initiated by established patients of the provider's practice.

Virtual check-in and e-visit telehealth services are not covered or billable if they:

- Take place during an in-person visit.
- Take place within seven days after an in-person visit furnished by the same provider.
- Trigger an in-person visit within 24 hours or the soonest available appointment.
- Do not have sufficient information from the remote evaluation of an image or video (store and forward) for the provider to complete the service.

Only the relevant in-person procedure code that was rendered would be reimbursed if any of the above conditions apply.

Telemedicine Evaluation and Management Services

ForwardHealth allows the following procedure codes to be reimbursable for telemedicine E&M services:

Telemedicine Services Procedure Code	Description
98000	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
98001	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98002	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98003	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
98004	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
98005	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98006	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98007	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
98008	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
98009	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes

	must be met or exceeded.
98010	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98011	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
98012	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.
98013	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98014	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98015	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
98016	Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion.

Prior Authorization

3

Archive Date:07/01/2025

Prior Authorization:Services Requiring Prior Authorization

Topic #529

Aural Rehabilitation Therapy Following a Cochlear Implant

Providers are required to complete and submit the following forms to ForwardHealth to request PA (prior authorization) for aural rehabilitation services for members who have reached 35 treatment days in their lifetime and require aural rehabilitation therapy from a speech-language pathologist immediately following a cochlear implant:

- PA/RF (Prior Authorization Request Form, F-11018 (05/2013))
- PA/TA (Prior Authorization/Therapy Attachment, F-11008 (04/2025))

Prior Authorization/Therapy Attachment

Providers are required to submit the entire PA/TA (all three pages of the PA/TA) but are only required to complete the following elements of the form:

- Section I, Elements 1–12. In Element 12 (Requested Start Date), providers are required to enter the date of stimulation.
- Section II, Element 13. Providers are required to clearly identify the following:
  - Date of cochlear implant surgery, in MM/DD/CCYY format.
  - Date of stimulation, in MM/DD/CCYY format.
  - Pre-linguist or post-linguist (applies only to members over 18 years of age).
- Section VIII, Element 22 (SIGNATURE — Providing Therapist) and Element 23 (Date Signed).

Established Grant Date

The grant date of approved PA requests for therapy services will be the initial stimulation date. Wisconsin Medicaid must receive the PA request no more than 30 calendar days before the stimulation date, or no more than 14 days after the stimulation date.

Aural Rehabilitation Services for Members Under 18 Years of Age Following a Cochlear Implant

Wisconsin Medicaid will grant a maximum of 60 visits of aural rehabilitation therapy over a 20-week period following the stimulation date of the cochlear implant for members under 18 years of age. The grant date of the PA request will be the stimulation date. The expiration date will be 20 weeks from the stimulation date.

Aural Rehabilitation Services for Members 18 Years of Age and Older Following a Cochlear Implant

Wisconsin Medicaid will grant a maximum of 13 weekly visits of aural rehabilitation therapy over 13 weeks following the stimulation date of the cochlear implant for members 18 years of age and older with post-linguistic skills. The grant date of the PA request will be the stimulation date. The expiration date will be 13 weeks from the stimulation date.

For members 18 years of age and older with pre-linguistic skills, Wisconsin Medicaid will grant a maximum of 26 visits over 26

weeks of aural rehabilitation therapy following the stimulation date of the cochlear implant. The grant date of the PA request will be the stimulation date. The expiration date will be 26 weeks from the stimulation date.

Requesting Extension of Aural Rehabilitation Therapy

Subsequent PA requests to extend therapy services will require completion of the entire PA/TA, as well as attachment of the required documentation indicated in the PA/TA Instructions (F-11008A (04/2025)). Wisconsin Medicaid may approve subsequent PA requests for a period of up to six months if the documentation submitted supports the medical necessity of the request.

Procedure Codes

Providers are required to use CPT (Current Procedural Terminology) procedure code 92626 (Evaluation of auditory function for surgically implanted device[s] candidacy or postoperative status of a surgically implanted device[s]; first hour) and, if warranted, procedure code 92627 (Evaluation of auditory function for surgically implanted device[s] candidacy or postoperative status of a surgically implanted device[s]; each additional 15 minutes) for evaluation and re-evaluation. Providers are required to use procedure code 92507 (Treatment of speech, language, voice, communication, and/or auditory processing disorder) with modifier UC (therapy following a cochlear implant) for aural rehabilitation following a cochlear implant. The use of modifier UC represents services for the improvement of speech and language related to the cochlear implant and results in increased reimbursement.

Members commonly receive SLP (speech and language pathology) services prior to receiving a cochlear implant. Providers should submit claims for procedure code 92507 without modifier UC for these services.

Maximum Allowable Number of Visits and Weeks

The following table provides the Wisconsin Medicaid maximum allowable number of visits and weeks for aural rehabilitation services following the date of stimulation of a cochlear implant that will be approved on a PA request:

Members	Maximum Allowable Number of Visits	Maximum Allowable Number of Weeks
Members Under 18 Years of Age	60	20
Members 18 Years of Age and Older — Post-Linguistic	13	13
Members 18 Years of Age and Older — Pre-Linguistic	26	26

Topic #2728

Cotreatment

Cotreatment is simultaneous treatment by two providers of different therapy disciplines during the same time period. Cotreatment does not include professional collaboration or consultation. Cotreatment may be eligible for reimbursement when the treatment approach is medically necessary to optimize a member's benefit from therapy.

Birth to 3 Program Cotreatment

Each therapy provider who provides services through the Birth to 3 Program must submit these forms when requesting PA (prior authorization) for cotreatment services identified in a participant's IFSP (Individualized Family Service Plan):

- PA/RF (Prior Authorization Request Form, F-11018 (05/2013))
- PA/B3 (Prior Authorization/Birth to 3, F-11011 (07/2012))

Appropriateness of cotreatment is determined by the IFSP team and should be identified in the current IFSP. Any changes to a Birth to 3 participant's services, including changes to or addition of cotreatment, should be documented in the updated IFSP.

The PA/B3 is only required to be submitted once per child per therapy discipline and billing provider. Each provider involved in cotreatment services is required to complete a separate PA/RF and PA/B3 request unless the provider already has an initial PA/RF and PA/B3 submitted and approved for a participant.

Note: Therapy providers who provide cotreatment to Birth to 3 Program participants are **not required** to submit an additional PA/TA (Prior Authorization/Therapy Attachment, F-11008 (04/2025)) form for coverage of those services.

Outpatient Cotreatment

Both providers involved in cotreatment services are required to document this information in the member's POC (plan of care):

- A specific reason for the appropriateness of cotreatment
- Documentation verifying:
  - The reason an individual treatment from a single PT (physical therapy), OT (occupational therapy), or SLP (speech and language pathology) provider does not provide maximum benefit to the member.
  - Services of two different therapy disciplines, simultaneously performed, are required to treat the member.
- Identification of the other provider and therapy discipline

Cotreatment Reimbursement

The medical necessity of cotreatment must be documented in both providers' POCs and daily notes to be reimbursed by cotreatment. ForwardHealth can reimburse medically necessary cotreatment for the same time period. For example, if a member is treated by an OT provider and an SLP provider for one hour from 1–2 p.m., then both providers could each receive reimbursement for one hour. Determination of medical necessity for cotreatment services is subject to audit.

Topic #2727

Decubitus Ulcers

Treatment of decubitus ulcers using electrical stimulation always requires PA (prior authorization). When requesting PA for electrical stimulation of decubitus ulcers, the service should be requested as a manual electrical stimulation procedure. Wisconsin Medicaid reimburses only for the face-to-face time that the PT (physical therapy) provider is in attendance.

A PA request for electrical stimulation of decubitus ulcers must include documentation of the following:

- The character, size, etc., of the pressure sore
- The need for additional time for dressing changes
- Weekly measurements
- Weekly percentage change in size or healing

A PA for continuing electrical stimulation treatment is considered only when there has been interval formation of granulation tissue or a 25% reduction in area has occurred within 45 treatment days. When this rapid improvement has not occurred within 45 days, a PA request for continuing electrical stimulation treatment must include documentation of nursing protocols, positioning recommendations, and dietary recommendations.

Topic #2726

Dual Treatment

Dual treatment (intradisciplinary treatment) always requires PA (prior authorization). Dual treatment is treatment by two or more providers of the same therapy discipline from different agencies or organizations. Each of the providers involved in dual treatment is required to complete a separate PA request; the requests must be submitted at the same time. Providers may either mail the PA requests in the same envelope or fax them at the same time. The PA/RFs (Prior Authorization Request Form, F-11018 (05/2013)) may be submitted via the Web if both PA requests are mailed together or faxed at the same time.

Each provider's PA request for dual treatment must include the following:

- A specific request for dual treatment
- Identification of the other provider
- Procedures for coordination of the treatment plans
- Specific days of the week each provider will provide services
- The specific and unique contribution of each PT (physical therapy), OT (occupational therapy), or SLP (speech and language pathology) provider

Topic #2725

Extension of Therapy

PA (prior authorization) is required to extend PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services subsequent to the member's initial SOI (spell of illness). As specified in Wis. Admin. Code §§ DHS 107.16 (3)(e), 107.17(3)(e), and 107.18(3)(e), a PA request to extend therapy services (for example, continuation of therapy services) will not be approved in any of the following circumstances:

- The member shows no progress toward meeting or maintaining established and measurable treatment goals over a six-month period, or the member shows no ability within six months to carry over abilities gained from treatment in a facility to the member's home.
- The member's chronological or developmental age, lifestyle, or home situation indicates the stated goals are not appropriate for the member or serve no functional or maintenance purpose.
- The member has achieved independence in daily activities or can be supervised and assisted by restorative nursing personnel, active treatment staff, activity or recreation staff, caregivers, or family.
- The evaluation indicates the member's abilities are functional for the member's present lifestyle.
- The member shows no motivation, interest, or desire to participate in a PT, OT, or SLP program.
- Other therapies or services being provided are sufficient to meet the member's treatment needs.
- The procedures requested are not medical in nature or are not covered services. Inappropriate diagnoses for PT, OT, and SLP services and procedures of questionable medical necessity may not receive departmental authorization, depending upon the individual circumstances.

Topic #2724

Maintenance Therapy

PA (prior authorization) is required for maintenance therapy services. PA requests for maintenance therapy services must demonstrate skilled need to be considered for approval. Members with skilled need under a maintenance therapy program require ongoing and specialized care. Members with skilled need may:

- Require specialized knowledge and judgment of a PT (physical therapy), OT (occupational therapy), or SLP (speech and language pathology) provider are required to establish and monitor the therapy program, including:

    - Performing the initial evaluation and establishing the POC (plan of care).
    - Designing the HEP/PMP (Home Exercise Program/Preventative Maintenance Program) and monitoring the member's functional abilities.
    - Providing instruction to the member and/or caregiver(s).
    - Performing any necessary re-evaluations.
- Be unable to maintain functional abilities without skilled PT, OT, or SLP services.
- Have a severe or complex condition that prevents caregiver(s) from being able to safely and effectively provide treatment or support.
- Require continual adjustment of therapeutic input and/or constant use of therapeutic principles, based on their particular medical condition and POC.

Required Documentation

When evaluating a PA request for maintenance therapy services, ForwardHealth evaluates submitted documentation regarding the member's:

- Functional status.
- Cognitive abilities.
- Diagnoses and whether they are of a chronic or progressive nature.
- Other pertinent medical history.

In addition, ForwardHealth also considers whether:

- Routine participation in HEP/PMP by member (and caregiver[s], as appropriate) will increase efficacy of the overall POC and is expected when feasible.
- Available caregivers can assist the member in carrying out the HEP/PMP as needed.
- Treatment goals and anticipated outcomes allow the member to maintain abilities or prevent regression from their highest level of functional independence.
- The need for skilled intervention should be applicable regardless of the member's place of residence (for example, private residence, group home).
- A lack of specialized, ongoing care would endanger the member's health or safety.

Topic #2714

Overview

ForwardHealth requires PA (prior authorization) for the following:

- PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services provided subsequent to the member's initial SOI (spell of illness)
- PT, OT, and SLP services that require PA starting with the first day of treatment

PT, OT, and SLP services provided in schools do not count towards the initial SOI under BadgerCare Plus and Wisconsin Medicaid.

To avoid potential claim denials, providers are encouraged to request PA when they are unsure whether the member has received, or is currently receiving, PT, OT, or SLP services from another provider.

Topic #20217

Serial Casting

Serial casting (including the general casting procedures and supplies) is allowed under the initial SOI (spell of illness). After the first 35 visits covered by the initial SOI, PA (prior authorization) is required. All claims for serial casting with a corresponding approved PA must be submitted with the same procedure code that was indicated on the PA, regardless of the DOS (date of service).

Prior Authorization Documentation

Providers are required to submit the following to ForwardHealth when requesting PA for serial casting:

- The PA/RF (Prior Authorization Request Form, F-11018 (05/2013))
- The PA/TA (Prior Authorization/Therapy Attachment, F-11008 (04/2025))
- Medical documentation including medical need for serial casting.

Topic #2713

Services That Always Require Prior Authorization

These PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services require PA (prior authorization) starting with the first day of treatment:

- Dual treatment
- HealthCheck Other Services
- Services identified by unlisted procedure codes
- Treatment of decubitus ulcers
- Treatment for conditions resulting from intellectual disability

Topic #16637

Speech and Language Pathology Services Directly Following the Purchase of a Speech Generating Device

Providers are required to request PA (prior authorization) for SLP (speech and language pathology) services directly following the purchase of a ForwardHealth-prior authorized speech generating device for members who have reached 35 treatment days in their lifetime and require therapy from a speech-language pathologist directly following the purchase of a ForwardHealth-prior authorized speech generating device.

Providers may request PA using a simplified process or request PA for an extension of therapy services, as applicable.

Requesting Prior Authorization Using the Simplified Process

Providers may complete and submit the following forms to ForwardHealth when requesting PA for SLP services for members directly following the purchase of a ForwardHealth-prior authorized speech generating device:

- PA/RF (Prior Authorization Request Form, F-11018 (05/2013)).
- PA/TA (Prior Authorization/Therapy Attachment, F-11008 (04/2025)). Providers are required to submit the **entire** PA/TA, but are only required to complete the following elements:
  - Section I, Elements 1-12.
  - Section II, Element 13. Providers are required to clearly identify the name of the speech generating device.

- Section VIII, Elements 22-23. Providing therapists are required to sign and date the completed form.

Note: This simplified process does not apply to members who received a speech generating device prior to enrolling in Wisconsin Medicaid or BadgerCare Plus fee-for-service or to members who do not have an approved DME (durable medical equipment) PA for their speech generating device on file with ForwardHealth. Providers should refer to the Requesting an Extension of Therapy Services section for instructions about requesting PA in these instances.

Procedure Code

Providers are required to use CPT (Current Procedural Terminology) procedure code 92609 (Therapeutic services for the use of speech-generating device, including programming and modification) when requesting PA for SLP services directly following the purchase of a ForwardHealth-prior authorized speech generating device.

Adjudication Process

Before approving a PA request for SLP services directly following the purchase of a ForwardHealth-prior authorized speech generating device, ForwardHealth will confirm that there is an approved DME PA request on file for the speech generating device indicated in Section II, Element 13 of the PA/TA. The PA request for the speech generating device must have been approved within six months of the requested start date of the SLP services. If an approved PA request for the indicated speech generating device is not on file within those six months, the PA request for SLP services will be returned to the provider. Providers may then resubmit the PA request using the same PA/RF, a PA/TA completed in its entirety, and any corresponding supplemental documentation.

Grant and Expiration Dates

Providers are required to indicate the requested grant date for SLP services in Section I, Element 12 of the PA/TA. The requested grant (start) date of an approved PA request for SLP services directly following the purchase of a ForwardHealth-prior authorized speech generating device must be within the requested grant and expiration (end) dates for the speech generating device.

ForwardHealth must receive the PA request for SLP services directly following the purchase of a ForwardHealth-prior authorized speech generating device no more than 14 days after the date indicated in Element 12. In limited circumstances, providers may request to backdate a PA request for SLP services directly following the purchase of a ForwardHealth-prior authorized speech generating device; however, if certain criteria are not met, the PA request will be denied.

The expiration date of an approved PA request for SLP services directly following the purchase of a ForwardHealth-prior authorized speech generating device will be 26 weeks from the grant date.

Approved Services

ForwardHealth will approve 12 visits (12 DOS (dates of service)) of procedure code 92609 directly following the purchase of a ForwardHealth-prior authorized speech generating device. These visits may be used flexibly over six months.

Requesting an Extension of Therapy Services

Providers are not required to use the simplified PA process detailed above. Providers may request an extension of therapy services instead of using the simplified PA process if a member's needs for therapy services are expected to exceed 12 visits.

In some circumstances, the simplified PA process detailed above does not apply. Providers are required to request an extension of therapy services instead of using the simplified PA process in the following instances:

- If a member requires additional therapy services after the 12 approved visits

- If a member received a speech generating device prior to enrolling in Wisconsin Medicaid or BadgerCare Plus fee-for-service
- If a member owns a speech generating device but does not have an approved DME PA for their speech generating device on file with ForwardHealth

Providers are required to complete and submit a new PA/RF, the entire PA/TA, and any corresponding supplemental documentation to ForwardHealth when requesting an extension of therapy services.

Topic #2802

Unlisted Procedures

Services identified by unlisted procedure codes always require PA (prior authorization). Unlisted procedure codes include 97039 for PT (physical therapy) services, 97139 for PT and OT (occupational therapy) services, and 92700 for SLP (speech and language pathology) services. A PA request with one of these procedure codes should include an explanation of why no other procedure code accurately reflects the service being requested.

Forms and Attachments

Topic #960

An Overview

Depending on the service being requested, most PA (prior authorization) requests must be comprised of the following:

- The PA/RF (Prior Authorization Request Form, F-11018 (05/2013)), PA/DRF (Prior Authorization/Dental Request Form, F-11035 (06/2024)), or PA/HIAS1 (Prior Authorization Request for Hearing Instrument and Audiological Services, F-11020 (05/2013))
- A service-specific PA attachment(s)
- Additional supporting clinical documentation (Typical PA requirements regarding attachments may not apply for some HealthCheck Other Services PA requests.)

Topic #2736

Attachments

PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) providers have the following choices for PA attachments:

- The PA/TA (Prior Authorization/Therapy Attachment, F-11008 (04/2025))
- The PA/SOIA (Prior Authorization/Spell of Illness Attachment, F-11039 (10/2015))
- The PA/B3 (Prior Authorization/Birth to 3 Attachment, F-11011 (07/2012))

PT, OT, and SLP providers should use the PA/TA when requesting the following:

- Extension of therapy services
- Maintenance therapy services
- Services that require PA starting with the first day of treatment

PT, OT, and SLP providers should submit the PA/SOIA when requesting approval for SOI (spell of illness).

PT, OT, and SLP providers should submit the PA/B3 for Birth to 3 services.

Prior Authorization/Speech Generating Device, Synthesized

At the time that the speech-language pathologist recommends an SGD (speech-generating device) and relevant accessories for rental or purchase for a member, they will complete a report(s) with required content or the two optional forms:

- PA/SGD Skills and Needs Profile Attachment (Prior Authorization/Speech Generating Device Skills and Needs Profile Attachment, F-02494 (07/2019))
- PA/SGD Purchase Recommendation Attachment (Prior Authorization/Speech Generating Device Purchase Recommendation, F-02493 (07/2019))

Speech-language pathologists can alternatively complete report(s) in a format of their choosing with the required content found on the optional forms.

The billing provider is required to submit these forms or equivalent documentation to ForwardHealth when requesting PA for rental of synthesized SGD or purchase of synthesized SGDs, accessories, mounting systems, or software.

Topic #446

Attachments

In addition to the PA/RF (Prior Authorization Request Form, F-11018 (05/2013)), PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (05/2013)), or PA/DRF (Prior Authorization/Dental Request Form, F-11035 (06/2024)), a service-specific PA (prior authorization) attachment must be submitted with each PA request. The PA attachment allows a provider to document the clinical information used to determine whether or not the standards of medical necessity are met for the requested service(s). Providers should include adequate information for ForwardHealth to make a reasonable judgment about the case.

ForwardHealth will scan each form with a barcode as it is received, which will allow greater efficiencies for processing PA requests.

Topic #447

Obtaining Forms and Attachments

Providers may obtain paper versions of all PA (prior authorization) forms and attachments. In addition, providers may download and complete most PA attachments from the ForwardHealth Portal.

Paper Forms

Paper versions of all PA forms and PA attachments are available by writing to ForwardHealth. Include a return address, the name of the form, the form number (if applicable), and mail the request to the following address:

ForwardHealth
Form Reorder
313 Blettner Blvd
Madison WI 53784

Providers may also call Provider Services to order paper copies of forms.

Downloadable Forms

Most PA attachments can be downloaded and printed in their original format from the Portal. Many forms are available in fillable PDF and fillable Microsoft Word formats.

Web PA Via the Portal

Certain providers may complete the PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) and PA attachments through the Portal. Providers may then print the PA/RF (and in some cases the PA attachment), and send the PA/RF, service-specific PA attachments, and any supporting documentation on paper by mail or fax to ForwardHealth.

Topic #448

Prior Authorization Request Form

The PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) is used by ForwardHealth and is mandatory for most providers when requesting PA (prior authorization). The PA/RF serves as the cover page of a PA request.

Providers are required to complete the basic provider, member, and service information on the PA/RF. Each PA request is assigned a unique ten-digit number. ForwardHealth remittance information will report to the provider the PA number used to process the claim for prior authorized services.

Topic #2735

Prior Authorization Request Form Completion Instructions for Therapy Services

The following sample PA/RFs (Prior Authorization Request Form) for therapy services are available:

- PT (physical therapy)
- OT (occupational therapy)
- SLP (speech and language pathology)

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (Wis. Admin. Code § DHS 104.02[4]).

Under Wis. Stat. § 49.45(4), personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing PA (prior authorization) requests, or processing provider claims for reimbursement. The use of the PA/RF (F-11018 (05/2013)) is mandatory to receive PA for certain items. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests, along with the PA/SOIA (Prior Authorization/Spell of Illness Services Attachment, F-11039 (10/2015)) and the PA/B3 (Prior Authorization/Birth to 3 Attachment, F-11011 (07/2012)), by fax to ForwardHealth at 608-221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — HealthCheck "Other Services" and Wisconsin Chronic Disease Program (WCDP)

Enter an "X" in the box next to HealthCheck "Other Services" if the services requested on the PA/RF are for HealthCheck "Other Services." Enter an "X" in the box next to WCDP (Wisconsin Chronic Disease Program) if the services requested on the PA/RF are for a WCDP member.

Element 2 — Process Type
Enter the appropriate three-digit process type from the list below. The process type is a three-digit code used to identify a category of service requested. Use process type 999 (Other) only if the requested category of service is not found in the list. PA and SOI (spell of illness) requests will be returned without adjudication if no process type is indicated.

*111 — PT
*112 — OT
*113 — SLP
*114 — SOI for PT
*115 — SOI for OT
*116 — SOI for SLP
160 — Birth to 3 for PT
161 — Birth to 3 for OT
162 — Birth to 3 for SLP
999 — Other (use only if the requested category or service is not listed above)

*Includes rehabilitation agencies.

Element 3 — Telephone Number — Billing Provider
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 4 — Name and Address — Billing Provider
Enter the name and complete address (street, city, state, and ZIP+4 code) of the billing provider. Providers are required to include both the ZIP code and four-digit extension for timely and accurate billing. The name listed in this element must correspond with the billing provider number listed in Element 5a.

Element 5a — Billing Provider Number
Enter the NPI (National Provider Identifier) of the billing provider. The NPI in this element must correspond with the provider name listed in Element 4.

Element 5b — Billing Provider Taxonomy Code
Enter the national 10-digit alphanumeric taxonomy code that corresponds to the NPI of billing provider number in Element 5a.

Element 6a — Name — Prescribing / Referring / Ordering Provider
Enter the prescribing/referring/ordering provider's name.

Element 6b — National Provider Identifier — Prescribing / Referring / Ordering Provider
Enter the prescribing/referring/ordering provider's 10-digit NPI.

SECTION II — MEMBER INFORMATION

Element 7 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or Wisconsin's EVS (Enrollment Verification System) to obtain the correct number.

Element 8 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

Element 9 — Address — Member
Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code. If the member is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 10 — Name — Member
Enter the member's last name, followed by their first name and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 11 — Gender — Member
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS — TREATMENT INFORMATION

Element 12 — Diagnosis — Primary Code and Description
Enter the appropriate ICD (International Classification of Diseases) diagnosis code and description with the highest level of specificity most relevant to the service/procedure requested. The ICD diagnosis code must correspond with the ICD description.

Element 13 — Start Date — SOI
Complete this element only when requesting an SOI. Enter the date of onset for the SOI in mm/dd/ccyy format.

Element 14 — First Date of Treatment — SOI
Complete this element only when requesting an SOI. Enter the date of the first treatment for the SOI in MM/DD/CCYY format.

Element 15 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD diagnosis code and description with the highest level of specificity most relevant to the service/procedure requested, if applicable. If requesting an SOI, leave this element blank.

Element 16 — Requested PA Start Date
Enter the requested start date for service(s) in mm/dd/ccyy format, if a specific start date is requested. If requesting an SOI, leave this element blank.

Element 17 — Rendering Provider Number
Enter the NPI of the provider who will be performing the service, **only** if the NPI is different from the NPI of the billing provider listed in Element 5a. If the treating therapist is the therapy assistant, enter the provider number of the supervising therapist. Rehabilitation agencies and outpatient hospital PT, OT, and SLP providers do not indicate a rendering provider number.

Element 18 — Rendering Provider Taxonomy Code
Enter the national 10-digit alphanumeric taxonomy code that corresponds to the provider who will be performing the service, *only* if this code is different from the taxonomy code listed for the billing provider in Element 5b. If the treating therapist is a therapy assistant, enter the provider number of the supervising therapist. Rehabilitation agencies and outpatient hospital PT, OT, and SLP providers do not indicate a rendering provider number.

Element 19 — Service Code
Enter the appropriate CPT (Current Procedural Terminology) code or HCPCS (Healthcare Common Procedure Coding System) code for each service/procedure/item requested. Do not complete this element if requesting a Birth to 3 Program service.

Element 20 — Modifiers
Enter the modifier(s) corresponding to the procedure code listed if a modifier is required. Enter the "GP" modifier for PT services, the "GO" modifier for OT services, and the "GN" modifier for SLP services. Do not enter modifiers TF (intermediate level of care) or TL (Early intervention/individualized family service plan [IFSP]).

Element 21 — POS

Enter the appropriate POS (place of service) code designating where the requested service/procedure/item would be provided/performed/dispensed.

Element 22 — Description of Service
Enter a written description corresponding to the appropriate CPT code or HCPCS code for each service/procedure/item requested. If requesting a Birth to 3 Program service, enter "Birth to 3" and the therapy discipline as the description (for example, "Birth to 3 occupational therapy services" for OT services).

Element 23 — QR
Enter the appropriate quantity (for example, number of services, days' supply) requested for the procedure code listed.

Element 24 — Charge
Enter the provider's usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to provider *Terms of Reimbursement* issued by the DHS (Department of Health Services).

Element 25 — Total Charges
Enter the anticipated total charges for this request.

Element 26 — Signature — Requesting Provider
The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 27 — Date Signed
Enter the month, day, and year the PA/RF was signed (in mm/dd/ccyy format).

Sample PA/RF for Physical Therapy Services

DEPARTMENT OF HEALTH SERVICES
ForwardHealth
F-11018 (05/13)

STATE OF WISCONSIN
DHS 106.03(4), Wis. Admin. Code
DHS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type	3. Telephone Number — Billing Provider
☐ HealthCheck "Other Services" ☐ Wisconsin Chronic Disease Program (WCDP)	111	(555) 555-5555

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)	5a. Billing Provider Number	5b. Billing Provider Taxonomy Code
I.M. BILLING PROVIDER 609 WILLOW ST ANYTOWN WI 55555-1234	0222222220	123456789X

6a. Name — Prescribing / Referring / Ordering Provider	6b. National Provider Identifier — Prescribing / Referring / Ordering Provider
I.M. PRESCRIBING PROVIDER	0111111110

SECTION II — MEMBER INFORMATION

7. Member Identification Number	8. Date of Birth — Member	9. Address — Member (Street, City, State, ZIP Code)
1234567890	MM/DD/CCYY	322 RIDGE ST ANYTOWN WI 55555

10. Name — Member (Last, First, Middle Initial)	11. Gender — Member
MEMBER, IM A	☐ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

12. Diagnosis — Primary Code and Description	13. Start Date — SOI	14. First Date of Treatment — SOI
I63.30 — Cerebral infarction due to thombos unsp cerebral artery		

15. Diagnosis — Secondary Code and Description							16. Requested PA Start Date			
Z92.82 — S/P admn tPA in diff fac w/n last 24 hr bef adm to crnt fac										
17. Rendering Provider Number	18. Rendering Provider Taxonomy Code	19. Service Code	20. Modifiers 1	2	3	4	21. POS	22. Description of Service	23. QR	24. Charge
0222222220	123456789X	97116	GP				11	Gait training/transferring, 15 min x 3/wk x 11 wks	33	XXX.XX
0222222220	123456789X	97110	GP				11	Strengthening exercises, 15 min x 3/wk x 11 wks	33	XXX.XX
0222222220	123456789X	G0283	GP				11	Unattended E stim, not for wound care, 1/day x 3 days	3	XXX.XX
An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.									25. Total Charges	XXX.XX
26. **SIGNATURE** — Requesting Provider									27. Date Signed	
I.M. Requesting Provider									MM/DD/CCYY	

Sample PA/RF for Occupational Therapy Services

DEPARTMENT OF HEALTH SERVICES
ForwardHealth
F-11018 (05/13)

STATE OF WISCONSIN
DHS 106.03(4), Wis. Admin. Code
DHS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type	3. Telephone Number — Billing Provider
❑ HealthCheck "Other Services" ❑ Wisconsin Chronic Disease Program (WCDP)	112	(555) 555-5555
4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code) I.M. BILLING PROVIDER 609 WILLOW ST ANYTOWN WI 55555-1234		5a. Billing Provider Number 0222222220 5b. Billing Provider Taxonomy Code 123456789X
6a. Name — Prescribing / Referring / Ordering Provider I.M. PRESCRIBING PROVIDER		6b. National Provider Identifier — Prescribing / Referring / Ordering Provider 0111111110

SECTION II — MEMBER INFORMATION

7. Member Identification Number	8. Date of Birth — Member	9. Address — Member (Street, City, State, ZIP Code)
1234567890	MM/DD/CCYY	322 RIDGE ST ANYTOWN WI 55555
10. Name — Member (Last, First, Middle Initial)	11. Gender — Member	
MEMBER, IM A	❑ Male ☒ Female	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

12. Diagnosis — Primary Code and Description	13. Start Date — SOI	14. First Date of Treatment — SOI
I63.30 — Cerebral infarction due to thombos unsp cerebral artery		

15. Diagnosis — Secondary Code and Description							16. Requested PA Start Date			
Z92.82 — S/P admn tPA in diff fac w/n last 24 hr bef adm to crnt fac										
17. Rendering Provider Number	18. Rendering Provider Taxonomy Code	19. Service Code	20. Modifiers 1	2	3	4	21. POS	22. Description of Service	23. QR	24. Charge
0222222220	123456789X	97110	GO				11	Srengthening exercises, 15 min x 3/wk x 11 wks	33	XXX.XX

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.	25. Total Charges	XXX.XX
26. **SIGNATURE** — Requesting Provider *I.M. Requesting Provider*	27. Date Signed MM/DD/CCYY	

Sample PA/RF for Speech and Language Pathology Services

DEPARTMENT OF HEALTH SERVICES
ForwardHealth
F-11018 (05/13)

STATE OF WISCONSIN
DHS 106.03(4), Wis. Admin. Code
DHS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type	3. Telephone Number — Billing Provider
❑ HealthCheck "Other Services" ❑ Wisconsin Chronic Disease Program (WCDP)	113	(555) 555-5555

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)	5a. Billing Provider Number	5b. Billing Provider Taxonomy Code
I.M. BILLING PROVIDER 609 WILLOW ST ANYTOWN WI 55555-1234	0222222220	123456789X

6a. Name — Prescribing / Referring / Ordering Provider	6b. National Provider Identifier — Prescribing / Referring / Ordering Provider
I.M. PRESCRIBING PROVIDER	0111111110

SECTION II — MEMBER INFORMATION

7. Member Identification Number	8. Date of Birth — Member	9. Address — Member (Street, City, State, ZIP Code)
1234567890	MM/DD/CCYY	322 RIDGE ST ANYTOWN WI 55555

10. Name — Member (Last, First, Middle Initial)	11. Gender — Member
MEMBER, IM A	❑ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

12. Diagnosis — Primary Code and Description	13. Start Date — SOI	14. First Date of Treatment — SOI
F80.1 — Expressive language disorder		

15. Diagnosis — Secondary Code and Description	16. Requested PA Start Date
R62.0 — Delayed milestone in childhood	MM/DD/CCYY

17. Rendering Provider Number	18. Rendering Provider Taxonomy Code	19. Service Code	20. Modifiers 1	2	3	4	21. POS	22. Description of Service	23. QR	24. Charge
0222222220	123456789X	92523	GN				11	Speech/Language Evaluation	1	XXX.XX
0222222220	123456789X	92507	GN				11	Speech/Language Therapy	17	XXX.XX
0222222220	123456789X	92508	GN				11	Group Speech/Language Therapy	17	XXX.XX

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.	25. Total Charges	XXX.XX
26. **SIGNATURE** — Requesting Provider	27. Date Signed	

I.M. Requesting Provider | MM/DD/CCYY

Topic #449

Supporting Clinical Documentation

Certain PA (prior authorization) requests may require additional supporting clinical documentation to justify the medical necessity for a service(s). Supporting documentation may include, but is not limited to, X-rays, photographs, a physician's prescription, clinical reports, and other materials related to the member's condition.

All supporting documentation submitted with a PA request must be clearly labeled and identified with the member's name and member identification number. Securely packaged X-rays and dental models will be returned to providers.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

Review Process

Topic #450

Clerical Review

The first step of the PA (prior authorization) request review process is the clerical review. The provider, member, diagnosis, and treatment information indicated on the PA/RF (Prior Authorization Request Form, F-11018 (05/2013)), PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (05/2013)), and PA/DRF (Prior Authorization/Dental Request Form, F-11035 (06/2024)) forms is reviewed during the clerical review of the PA request review process. The following are examples of information verified during the clerical review:

- Billing and/or rendering provider number is correct and corresponds with the provider's name.
- Provider's name is spelled correctly.
- Provider is Medicaid-enrolled.
- Procedure codes with appropriate modifiers, if required, are covered services.
- Member's name is spelled correctly.
- Member's identification number is correct and corresponds with the member's name.
- Member enrollment is verified.
- All required elements are complete.
- Forms, attachments, and additional supporting clinical documentation are signed and dated.
- A current physician's prescription for the service is attached, if required.

Clerical errors and omissions are responsible for the majority of PA requests that are returned to providers for correction or additional information. Since having to return a PA request for corrections or additional information can delay approval and delivery of services to a member, providers should ensure that all clerical information is correctly and completely entered on the PA/RF, PA/DRF, or PA/HIAS1.

If clerical errors are identified, the PA request is returned to the provider for corrections before undergoing a clinical review. One way to reduce the number of clerical errors is to complete and submit PA/RFs through Web PA.

Topic #451

Clinical Review

Upon verifying the completeness and accuracy of clerical items, a PA (prior authorization) request is reviewed to evaluate whether or not each service being requested meets Wisconsin Medicaid's definition of "medically necessary," as well as other criteria.

The PA attachment allows a provider to document the clinical information used to determine whether the standards of medical necessity are met for the requested service. Wisconsin Medicaid considers certain factors when determining whether to approve or deny a PA request pursuant to Wis. Admin. Code § DHS 107.02(3)(e).

It is crucial that a provider include adequate information on the PA attachment so that the ForwardHealth consultant performing the clinical review can determine that the service(s) being requested meets all the elements of Wisconsin Medicaid's definition of "medically necessary," including elements that are not strictly medical in nature. Documentation must provide the justification for the service requested specific to the member's current condition and needs. Pursuant to Wis. Admin. Code § DHS 101.03(96m), "medically necessary" is a service under Wis. Admin. Code ch. DHS 107 that meets certain criteria.

Determination of Medical Necessity

The definition of "medically necessary" is a legal definition identifying the standards that must be met for approval of the service. The definition imposes parameters and restrictions that are both medical and nonmedical.

The determination of medical necessity is based on the documentation submitted by the provider. For this reason, it is essential that documentation is submitted completely and accurately and that it provides the justification for the service requested, specific to the member's current condition and needs. To be approved, a PA request must meet all of the standards of medical necessity including those that are not strictly medical in nature.

To determine if a requested service is medically necessary, ForwardHealth consultants obtain direction and/or guidance from multiple resources including:

- Federal and state statutes
- Wisconsin Administrative Code
- PA guidelines set forth by Wisconsin DHS (Department of Health Services)
- Standards of practice
- Professional knowledge
- Scientific literature

Decisions

Topic #424

Approved Requests

PA (Prior authorization) requests are approved for varying periods of time based on the clinical justification submitted. The provider receives a copy of a PA decision notice when a PA request for a service is approved. Providers may then begin providing the approved service on the grant date given.

An approved request means that the requested **service**, not necessarily the code, was approved. For example, a similar procedure code may be substituted for the originally requested procedure code. Providers are encouraged to review approved PA requests to confirm the services authorized and confirm the assigned grant and expiration dates.

Listing Procedure Codes Approved as a Group on the Decision Notice Letter

In certain circumstances, ForwardHealth will approve a PA request for a group of procedure codes with a total quantity approved for the entire group. When this occurs, the quantity approved for the entire group of codes will be indicated with the first procedure code. All of the other approved procedure codes within the group will indicate a quantity of zero.

Providers may submit claims for any combination of the procedure codes in the group up to the approved quantity.

Topic #4724

Communicating Prior Authorization Decisions

ForwardHealth will make a decision regarding a provider's PA (prior authorization) request within 20 working days from the receipt of all the necessary information. After processing the PA request, ForwardHealth will send the provider either a decision notice letter or a returned provider review letter. Providers will receive a decision notice letter for PA requests that were approved, approved with modifications, or denied. Providers will receive a returned provider review letter for PA requests that require corrections or additional information. The decision notice letter or returned provider review letter will clearly indicate what is approved or what correction or additional information ForwardHealth needs to continue adjudicating the PA request.

Providers submitting PA requests via the ForwardHealth Portal will receive a decision notice letter or returned provider review letter via the Portal.

If the provider submitted a PA request via mail or fax and the provider has a Portal account, the decision notice letter or returned provider review letter will be sent to the provider via the Portal, as well as by mail.

If the provider submitted a paper PA request via mail or fax and does not have a Portal account, the decision notice letter or returned provider review letter will be sent to the address indicated in the provider's file as their PA address (or to the physical address if there is no PA address on file), **not** to the address the provider wrote on the PA request.

The decision notice letter or returned provider review letter will not be faxed back to providers who submitted their paper PA request via fax. Providers who submitted their paper PA request via fax will receive the decision notice letter or returned provider letter via mail.

Topic #5038

Correcting Returned Prior Authorization Requests and Request Amendments on the Portal

If a provider received a returned provider review letter or an amendment provider review letter, they will be able to correct the errors identified on the returned provider review letter directly on the ForwardHealth Portal. Once the provider has corrected the error(s), the provider can resubmit the PA (prior authorization) request or amendment request via the Portal to ForwardHealth for processing. When correcting errors, providers only need to address the items identified in the returned provider review letter or the amendment provider review letter. Providers are not required to resubmit PA information already submitted to ForwardHealth.

Topic #5037

Decision Notice Letters and Returned Provider Review Letters on the Portal

Providers can view PA (prior authorization) decision notices and provider review letters via the secure area of the ForwardHealth Portal. PA decision notices and provider review letters can be viewed when the PA is selected on the Portal.

Note: The PA decision notice or the provider review letter will not be available until the day after the PA request is processed by ForwardHealth.

Topic #425

Denied Requests

When a PA (prior authorization) request is denied, both the provider and the member are notified. The provider receives a PA decision notice, including the reason for PA denial. The member receives a Notice of Appeal Rights letter that includes a brief statement of the reason PA was denied and information about their right to a fair hearing. Only the **member, or authorized person acting on behalf of the member**, can appeal the denial.

Providers may call Provider Services for clarification of why a PA request was denied.

Providers are required to discuss a denied PA request with the member and are encouraged to help the member understand the reason the PA request was denied.

Providers have three options when a PA request is denied:

- Not provide the service.
- Submit a **new** PA request. Providers are required to submit a copy of the original denied PA request and additional supporting clinical documentation and medical justification along with a new PA/RF (Prior Authorization Request Form, F-11018 (05/2013)), PA/DRF (Prior Authorization/Dental Request Form, F-11035 (06/2024)), or PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (05/2013)).
- Provide the service as a noncovered service.

If the member does not appeal the decision to deny the PA request or appeals the decision but the decision is upheld and the member chooses to receive the service anyway, the member may choose to receive the service(s) as a noncovered service.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

   Division of Hearings and Appeals
   Department of Administration
   PO Box 7875
   Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #426

Modified Requests

Modification is a change in the services originally requested on a PA (prior authorization) request. Modifications could include, but are not limited to, either of the following:

- The authorization of a procedure code different than the one originally requested.
- A change in the frequency or intensity of the service requested.

When a PA request is modified, both the provider and the member are notified. The provider will be sent a decision notice letter. The decision notice letter will clearly indicate what is approved or what correction or additional information is needed to continue adjudicating the PA request. The member receives a Notice of Appeal Rights letter that includes a brief statement of the reason PA was modified and information on their right to a fair hearing. Only the **member, or authorized person acting on behalf of the member**, can appeal the modification.

Providers are required to discuss with the member the reasons a PA request was modified.

Providers have the following options when a PA request is approved with modification:

- Provide the service as authorized.
- Submit a request to amend the modified PA request. Additional supporting clinical documentation and medical justification must be included.
- Not provide the service.
- Provide the service as originally requested as a noncovered service.

If the member does not appeal the decision to modify the PA request or appeals the decision but the decision is upheld and the member chooses to receive the originally requested service anyway, the member may choose to receive the service(s) as a noncovered service.

Providers may call Provider Services for clarification of why a PA request was modified.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

XXXXXXXXXXXXXXXXXXXXXXXXX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

    Division of Hearings and Appeals
    Department of Administration
    PO Box 7875
    Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.

- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #4737

Returned Provider Review Letter Response Time

Thirty Days to Respond to the Returned Provider Review Letter

ForwardHealth must receive the provider's response within 30 calendar days of the date on the returned provider review letter, whether the letter was sent to the provider by mail or through the ForwardHealth Portal. If the provider's response is received within 30 calendar days, ForwardHealth still considers the original receipt date on the PA (prior authorization) request when authorizing a grant date for the PA.

If a provider needs more than 30 days to submit the requested information, providers can request an extension by submitting a letter that explains why more time is needed to gather and submit the additional information requested. The letter seeking an extension must be submitted within the initial 30 calendar days of receiving the returned provider review letter.

Instructions for how to submit the letter can be found in the ForwardHealth Provider Portal Prior Authorization User Guide. If a provider wants to submit the letter via mail or fax, the provider must ensure it is received within the 30 days. While mailed or faxed letters are accepted, providers are encouraged to submit the letter via electronic upload.

Providers will be notified in a manner similar to how they submitted their letter, and the new deadline will be included in that notification. Providers who mail their submissions will receive a notification in the mail. Providers who electronically upload their submission will receive a notification in the Portal, etc.

If ForwardHealth does not receive the provider's response within 30 calendar days of the date the returned provider review letter was sent, the PA status becomes inactive and the provider is required to submit a new PA request. This results in a later grant date if the PA request is approved. Providers will not be notified when their PA request status changes to inactive, but this information will be available on the Portal and through WiCall.

If ForwardHealth receives additional information from the provider after the 30-day deadline has passed, a letter will be sent to the provider stating that the PA request is inactive and the provider is required to submit a new PA request.

Topic #427

Returned Requests

A PA (prior authorization) request may be returned to the provider when forms are incomplete, inaccurate, or additional clinical information or corrections are needed. When this occurs, the provider will be sent a provider review letter.

Returned Provider Review Letter

The returned provider review letter will indicate the PA number assigned to the request and will specify corrections or additional information needed on the PA request. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct PAs that have been placed in returned provider review status in the ForwardHealth Portal.

If providers require more than 30 days submit corrections or required additional information, they can request an extension by submitting a letter that explains why more time is needed. The letter requesting an extension must be submitted within the initial 30 calendar days of receiving the returned provider review letter.

Instructions for how to submit the letter can be found in the ForwardHealth Provider Portal Prior Authorization User Guide. If a provider wants to submit the letter via mail or fax, the provider must ensure it is received within the 30 days. While mailed or faxed letters are accepted, providers are encouraged to submit the letter via electronic upload.

Providers will be notified in a manner similar to how they submitted their letter, and the new deadline will be included in that notification. Providers who mail their submissions will receive a notification in the mail. Providers who electronically upload their submission will receive a notification in the Portal, etc.

The provider's paper documents submitted with the PA request will not be returned to the provider when corrections or additional information are needed; however, X-rays and dental models will be returned once the PA is finalized.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

Therefore, providers are required to make a copy of their PA requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if more information is required about the PA request.

Note: When changing or correcting the PA request, providers are reminded to revise or update the documentation retained in their records.

Follow-Up to Decisions

Topic #4738

Amendment Decisions

ForwardHealth will make a decision regarding a provider's amendment request within 20 working days from the receipt of all the necessary information. The method ForwardHealth will use to communicate decisions regarding PA (prior authorization) amendment requests will depend on how the **PA request** was originally submitted (not how the amendment request was submitted) and whether the provider has a ForwardHealth Portal account:

- If the PA request was originally submitted via the Portal, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal.
- If the PA request was originally submitted via mail or fax and the provider has a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal, as well as by mail.
- If the PA request was originally submitted via mail or fax and the provider does **not** have a Portal account, the decision notice letter or returned amendment provider review letter will be sent by mail to the address indicated in the provider's file as their PA address (or to the physical address if there is no PA address on file), **not** to the address the provider wrote on the PA request or amendment request.

Topic #2737

Prior Authorization Amendments for Therapy Services

Providers may request an amendment to a current approved or modified PA (prior authorization) request to change:

- The frequency of treatment.
- The grant and expiration date(s).
- The specific treatment code(s).

PA expiration dates may be amended up to one month beyond the original expiration date if the additional services are medically necessary, and PT (physical therapy), OT (occupational therapy), or SLP (speech and language pathology) services will be discontinued after this brief extension of services.

If the need for PT, OT, or SLP services is expected to continue for longer than one month beyond the expiration date, providers are required to submit a new PA request.

Providers are required to submit a new PA request (instead of requesting an amendment) if the member's medical condition changes significantly and requires a new POC (plan of care).

The request to amend the PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) should include:

- A copy of the original PA/RF.
- A Prior Authorization Amendment Request form.
- The specific, requested changes to the PA/RF.
- Documentation justifying the requested changes (This may include the POC, a new written report of the member's evaluation, treatment goals, etc.).

Members Under Age 6

If an authorization period of less than 12 months is granted, providers can submit a PA amendment to continue services up to 12 months per PA. Providers must submit an amendment request or a new PA request before the current PA expires to prevent a gap in services. Members are not required to be discharged at the end of the extension period.

Approval Criteria

ForwardHealth may approve an amendment request if:

- Documentation establishes that the amendment request is medically necessary.
- The request is received by the date of the requested change.

Reasons for Denial

ForwardHealth may deny an amendment request for reasons including, but not limited to:

- The request is not medically necessary.
- The request is solely for the convenience of the member, the member's family, or the provider.
- The request is not received before the date of the requested change.
- The PA expired prior to receipt of the amendment request.
- The member's medical condition changes significantly, requiring a new POC.
- The request is to allow for a vacation, missed appointments, illness, or a leave of absence by the provider.

Topic #431

Amendments

Providers are required to use the Prior Authorization Amendment Request (F-11042 (07/2012)) form to amend an approved or modified PA (prior authorization) request.

ForwardHealth does not accept a paper amendment request submitted on anything other than the Prior Authorization Amendment Request form. The Prior Authorization Amendment Request form may be submitted through the Portal, by mail or by fax. If ForwardHealth receives a PA amendment on a previous version of the Prior Authorization Amendment Request form, a letter will be sent to the provider stating that the provider is required to submit a new PA amendment request using the proper form.

Providers may request an amendment to an approved or modified PA request to:

- Temporarily modify a member's frequency of a service when there is a short-term change in their medical condition.
- Change the rendering provider information when the billing provider remains the same.
- Change the member's ForwardHealth identification number.
- Add or change a procedure code.

Note: ForwardHealth recommends that, under most circumstances, providers should enddate the current PA request and submit a new one if there is a significant, long-term change in services required.

Topic #432

Appeals

If a PA (prior authorization) request is denied or modified by ForwardHealth, only a member, or authorized person acting on behalf of the member, may file an appeal with the DHA (Division of Hearings and Appeals). Decisions that may be appealed include the following:

- Denial or modification of a PA request
- Denial of a retroactive authorization for a service

The member is required to file an appeal within 45 days of the date of the Notice of Appeal Rights.

To file an appeal, members may complete and submit a Request for Fair Hearing (DHA-28 (08/09)) form.

Though providers cannot file an appeal, they are encouraged to remain in contact with the member during the appeal process. Providers may offer the member information necessary to file an appeal and help present their case during a fair hearing.

Fair Hearing Upholds ForwardHealth's Decision

If the hearing decision upholds the decision to deny or modify a PA request, the DHA notifies the member and ForwardHealth in writing. The member may choose to receive the service (or in the case of a modified PA request, the originally requested service) as a noncovered service, not receive the service at all, or appeal the decision.

Fair Hearing Overturns ForwardHealth's Decision

If the hearing decision overturns the decision to deny or modify the PA request, the DHA notifies ForwardHealth and the member. The letter includes instructions for the provider and for ForwardHealth.

If the DHA letter instructs the provider to submit a claim for the service, the provider should submit the following to ForwardHealth after the service has been performed:

- A paper claim with "HEARING DECISION ATTACHED" written in red ink at the top of the claim
- A copy of the hearing decision
- A copy of the denied PA request

Providers are required to submit claims with hearing decisions to the following address:

ForwardHealth
Specialized Research
Ste 50
313 Blettner Blvd
Madison WI 53784

Claims with hearing decisions sent to any other address may not be processed appropriately.

If the DHA letter instructs the provider to submit a new PA request, the provider is required to submit the **new** PA request along with a copy of the hearing decision to the PA Unit at the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

ForwardHealth will then approve the PA request with the revised process date. The provider may then submit a claim following

the usual claims submission procedures after providing the service(s).

Financial Responsibility

If the member asks to receive the service **before** the hearing decision is made, the provider is required to notify the member before rendering the service that the member will be responsible for payment if the decision to deny or modify the PA request is upheld.

If the member accepts responsibility for payment of the service before the hearing decision is made, and if the appeal decision **upholds** the decision to deny or modify the PA request, the provider may collect payment from the member if certain conditions are met.

If the member accepts responsibility for payment of the service before the hearing decision is made, and if the appeal decision **overturns** the decision to deny or modify a PA request, the provider may submit a claim to ForwardHealth. If the provider collects payment from the member for the service before the appeal decision is overturned, the provider is required to refund the member for the **entire** amount of payment received from the member after the provider receives Medicaid's reimbursement.

Wisconsin Medicaid does not directly reimburse members.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

Division of Hearings and Appeals
Department of Administration
PO Box 7875
Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #1106

Enddating

Providers are required to use the Prior Authorization Amendment Request (F-11042 (07/2012)) to enddate most PA (prior authorization) requests. ForwardHealth does not accept requests to enddate a PA request for any service, except drugs, on anything other than the Prior Authorization Amendment Request. PA for drugs may be enddated by using STAT-PA (Specialized Transmission Approval Technology-Prior Authorization), in addition to submitting a Prior Authorization Amendment Request.

Providers may submit a Prior Authorization Amendment Request on the ForwardHealth Portal, or by fax or mail.

If a request to enddate a PA is not submitted on the Prior Authorization Amendment Request, a letter will be sent to the provider stating that the provider is required to submit the request using the proper forms.

Examples of when a PA request should be enddated include the following:

- A member chooses to discontinue receiving prior authorized services.
- A provider chooses to discontinue delivering prior authorized services.

Examples of when a PA request should be enddated and a new PA request should be submitted include the following:

- There is an interruption in a member's continual care services.
- There is a change in the member's condition that warrants a long-term change in services required.
- The service(s) is no longer medically necessary.

Topic #4739

Returned Amendment Provider Review Letter

If the amendment request needs correction or additional information, a returned amendment provider review letter will be sent. The letter will show how the PA (prior authorization) appears currently in the system, and providers are required to respond by correcting errors identified on the letter. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct an amendment request that has been placed in returned provider review status in the ForwardHealth Portal.

ForwardHealth must receive the provider's response within 30 calendar days of the date the returned amendment provider review letter was sent. If a provider requires more than 30 days to provide the corrections or additional required information, they can request an extension by submitting a letter that explains why more time is needed. The letter must be submitted via mail, fax, or electronic upload within the initial 30 calendar days of receiving the returned provider review letter.

Instructions for how to submit the letter can be found in the ForwardHealth Provider Portal Prior Authorization User Guide. If a provider wants to submit the letter via mail or fax, the provider must ensure it is received within the 30 days. While mailed or faxed letters are accepted, providers are encouraged to submit the letter via electronic upload.

Providers will be notified in a manner similar to how they submitted their letter, and the new deadline will be included in that notification. Providers who mail their submissions will receive a notification in the mail. Providers who electronically upload their submission will receive a notification in the Portal, etc.

After 30 days without a response, submission of the PA request or request for an extension, the amendment request status becomes inactive, and the provider is required to submit a new amendment request. The ForwardHealth interChange system will continue to use the original approved PA request for processing claims.

The provider's paper documents submitted with the amendment request will not be returned to the provider when corrections or additional information are needed; however, X-rays and dental models will be returned once the amendment request is finalized.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

Therefore, providers are required to make a copy of their amendment requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes

if ForwardHealth requires more information about the amendment request.

Note: When changing or correcting the amendment request, providers are reminded to revise or update the documentation retained in their records.

Topic #5039

Searching for Previously Submitted Prior Authorization Requests on the Portal

Providers will be able to search for all previously submitted PA (prior authorization) requests, regardless of how the PA was initially submitted. If the provider knows the PA number, they can enter the number to retrieve the PA information. If the provider does not know the PA number, they can search for a PA by entering information in one or more of the following fields:

- Member identification number
- Requested start date
- Prior authorization status
- Amendment status

If the provider does not search by any of the information above, providers will retrieve all their PA requests submitted to ForwardHealth.

Situations Requiring New Requests

Topic #452

Change in Billing Providers

Providers are required to submit a new PA (prior authorization) request when there is a change in billing providers. A new PA request must be submitted with the new billing provider's name and billing provider number. The expiration date of the PA request will remain the same as the original PA request.

Typically, as no more than one PA request is allowed for the same member, the same service(s), and the same dates, the new billing provider is required to send the following to ForwardHealth's PA Unit:

- A copy of the existing PA request, if possible
- A new PA request, including the required attachments and supporting documentation indicating the new billing provider's name and address and billing provider number
- A letter requesting the end-dating of the existing PA request (may be a photocopy) attached to each PA request with the following information:
  - The previous billing provider's name and billing provider number, if known
  - The new billing provider's name and billing provider number
  - The reason for the change of billing provider (The provider may want to confer with the member to verify that the services by the previous provider have ended. The new billing provider may include this verification in the letter.)
  - The requested effective date of the change

Topic #453

Examples

Examples of when a new PA (prior authorization) request must be submitted include the following:

- A provider's billing provider changes.
- A member requests a provider change that results in a change in billing providers.
- A member's enrollment status changes and there is not a valid PA on file for the member's current plan (BadgerCare Plus, Medicaid).

If the **rendering** provider indicated on the PA request changes but the **billing** provider remains the same, the PA request remains valid and a new PA request does **not** need to be submitted.

Topic #454

Services Not Performed Before Expiration Date

Generally, a new PA (prior authorization) request with a new requested start date must be submitted to ForwardHealth if the amount or quantity of prior authorized services is not used by the expiration date of the PA request and the service is still medically necessary.

Member Eligibility Changes

Topic #443

Loss of Enrollment During Treatment

Some covered services consist of sequential treatment steps, meaning more than one office visit or service is required to complete treatment.

In most cases, if a member loses enrollment midway through treatment, or at any time between the grant and end dates, Wisconsin Medicaid will **not** reimburse services (including prior authorized services) provided during an enrollment lapse. Providers should not assume Wisconsin Medicaid covers completion of services after the member's enrollment has been terminated.

To avoid potential reimbursement problems when a member loses enrollment during treatment, providers should follow these procedures:

- Ask to see the member's ForwardHealth identification card to verify the member's enrollment or consult Wisconsin's EVS (Enrollment Verification System) before the services are provided at each visit.
- When the PA (prior authorization) request is approved, verify that the member is still enrolled and eligible to receive the service before providing it. An approved PA request does not guarantee payment and is subject to the enrollment of the member.

Members are financially responsible for any services received after their enrollment has ended. If the member wishes to continue treatment, it is a decision between the provider and the member whether the service should be given and how payment will be made for the service.

To avoid misunderstandings, providers should remind members that they are financially responsible for any continued care after their enrollment ends.

Topic #444

Retroactive Disenrollment From State-Contracted MCOs

Occasionally, a service requiring fee-for-service PA (prior authorization) is performed during a member's enrollment period in a state-contracted MCO (managed care organization). After the service is provided, and it is determined that the member should be retroactively disenrolled from the MCO, the member's enrollment is changed to fee-for-service for the DOS (date of service). The member is continuously eligible for BadgerCare Plus or Wisconsin Medicaid but has moved from MCO enrollment to fee-for-service status.

In this situation, the state-contracted MCO would deny the claim because the member was not enrolled on the DOS. Fee-for-service would also deny the claim because PA was not obtained.

Providers may take the following steps to obtain reimbursement in this situation:

- For a service requiring PA for fee-for-service members, the provider is required to submit a retroactive PA request. For a PA request submitted on paper, indicate "RETROACTIVE FEE-FOR-SERVICE" along with a written description of the

service requested/provided under "Description of Service." Also indicate the actual date(s) the service(s) was provided. For a PA request submitted via the ForwardHealth Portal, indicate "RETROACTIVE FEE-FOR-SERVICE" along with a description of the service requested/provided under the "Service Code Description" field or include additional supporting documentation. Also indicate the actual date(s) the service(s) was provided.

- If the PA request is approved, the provider is required to follow fee-for-service policies and procedures for claims submission.
- If the PA request is denied, Wisconsin Medicaid will not reimburse the provider for the services. A PA request would be denied for reasons such as lack of medical necessity. A PA request would not be denied due to the retroactive fee-for-service status of the member.

Topic #445

Retroactive Enrollment

If a service(s) that requires PA (prior authorization) was performed during a member's retroactive enrollment period, the provider is required to submit a PA request and receive approval from ForwardHealth **before** submitting a claim. For a PA request submitted on paper, indicate the words "RETROACTIVE ENROLLMENT" at the top of the PA request along with a written description explaining that the service was provided at a time when the member was retroactively enrolled under "Description of Service." Also include the actual date(s) the service(s) was provided. For a PA request submitted via the ForwardHealth Portal, indicate the words "RETROACTIVE ENROLLMENT" along with a description explaining that the service was provided at a time when the member was retroactively eligible under the "Service Code Description" field or include additional supporting documentation. Also include the actual date(s) the service(s) was provided.

If the member was retroactively enrolled, and the PA request is approved, the service(s) may be reimbursable, and the earliest effective date of the PA request will be the date the member receives retroactive enrollment. If the PA request is denied, the provider will not be reimbursed for the service(s). Members have the right to appeal the decision to deny a PA request.

If a member requests a service that requires PA before his or her retroactive enrollment is determined, the provider should explain to the member that he or she may be liable for the full cost of the service if retroactive enrollment is not granted and the PA request is not approved. This should be documented in the member's record.

Emergent and Urgent Situations

Topic #429

Emergency Services

In emergency situations, the PA (prior authorization) requirement may be waived for services that normally require PA. Emergency services are defined in Wis. Admin. Code DHS 101.03(52) as "those services which are necessary to prevent the death or serious impairment of the health of the individual."

Reimbursement is not guaranteed for services that normally require PA that are provided in emergency situations. As with all covered services, emergency services must meet all program requirements, including medical necessity, to be reimbursed by Wisconsin Medicaid. For example, reimbursement is contingent on, but not limited to, eligibility of the member, the circumstances of the emergency, and the medical necessity of the services provided.

Wisconsin Medicaid will not reimburse providers for noncovered services provided in any situation, including emergency situations.

Topic #430

Urgent Services

Telephone consultations with DMS (Division of Medicaid Services) staff regarding a prospective PA (prior authorization) request can be given only in urgent situations when medically necessary. An urgent, medically necessary situation is one where a delay in authorization would result in undue hardship for the member or unnecessary costs for Medicaid as determined by DMS. All telephone consultations for urgent services should be directed to the Service Authorization section at 608-267-9311. Providers should have the following information ready when calling:

- Member's name
- Member ID number
- Service(s) needed
- Reason for the urgency
- Diagnosis of the member
- Procedure code of the service(s) requested

Providers are required to submit a PA request to ForwardHealth within 14 calendar days after the date of the telephone consultation. PA may be denied if the request is received more than two weeks after the consultation. If the PA request is denied in this case, the provider cannot request payment from the member.

General Information

Topic #4402

An Overview

The PA (prior authorization) review process includes both a clerical review and a clinical review. The PA request will have one of the statuses detailed in the following table.

Prior Authorization Status	Description
Approved	The PA request was approved.
Approved with Modifications	The PA request was approved with modifications to what was requested.
Denied	The PA request was denied.
Returned—Provider Review	The PA request was returned to the provider for correction or for additional information.
Pending—Fiscal Agent Review	The PA request is being reviewed by the Fiscal Agent.
Pending—Dental Follow-up	The PA request is being reviewed by a Fiscal Agent dental specialist.
Pending—State Review	The PA request is being reviewed by the State.
Suspend—Provider Sending Information	The PA request was submitted via the ForwardHealth Portal, and the provider indicated they will be sending additional supporting information on paper.
Inactive	The PA request is inactive due to no response within 30 days to the returned provider review letter and cannot be used for PA or claims processing.

Topic #2729

Approval Criteria

Comprehensive information about the member helps to establish the functional potential of the member and forms the basis for determining whether the member will benefit from the requested services. No single factor, such as diagnosis or age of the member, will result in automatic approval or denial of a PA (prior authorization) request for extension of therapy services, maintenance therapy services, or services that always require PA.

It is essential that documentation is complete, accurate, and specific to the member's current condition and needs. Providers are required to submit the following when submitting the PA/TA (Prior Authorization/Therapy Attachment, F-11008 (04/2025)):

- A written report of the member's evaluation.
- An individualized POC (plan of care) if not documented on the PA/TA.
- A copy of the IEP (Individualized Education Plan) if the member is a school-aged member (ages 3 up to 21).*
- A copy of the IPP (Interdisciplinary Program Plan) if the member is in a residential or day facility for the developmentally disabled. The IPP must document coordination and integration of the active treatment and medical care plan of the member.

* ForwardHealth does not require submitted documentation of coordination of care or the IEP for the initial PA of an episode of

therapy services. Elements 16 and 17 of the PA/TA do not need to be completed when requesting these services. An episode of therapy services lasts until the member is discharged from the current plan of care.

Also, per Wis. Admin. Code § DHS 90.07(3)(b), when submitting non-Birth to 3 PA requests for therapeutic services for children ages 0–3 years (for example, outpatient treatment PA requests for therapeutic services), providers must confirm that the child has been referred to the Birth to 3 Program. Confirmation of referral can be completed by, but is not limited to, caregiver discussion regarding the availability of the Birth to 3 Program, review of member medical records with confirmed referral in the record, or direct referral by the therapy provider to the Birth to 3 Program.

Providers may provide the IFSP (Individualized Family Service Plan) or Child Enrollment Status Regarding Birth to 3 Program (F-00316 (03/2017)) form as a method of confirmation that the child has been referred to the Birth to 3 Program, but the IFSP and Child Enrollment Status Regarding Birth to 3 Program form are not required to be submitted for children ages 0–3 years.

Providers should ensure that the method of confirmation of the referral is maintained in the member's medical records and is readily available upon audit requests.

Only one team member needs to submit the IEP or IPP with a PA request. The team should discuss who will submit the IEP or IPP. The other providers should reference the PA request that was submitted with the IEP or IPP by indicating the PA number and the date the PA was submitted. The team member designated to submit the IEP or IPP should receive an additional copy from the coordinator. If the member does not have an IEP or IPP, the provider is required to indicate the reason these documents do not exist.

Topic #434

Communication With Members

ForwardHealth recommends that providers inform members that PA (prior authorization) is required for certain specified services **before** delivery of the services. Providers should also explain that, if required to obtain PA, they will be submitting member records and information to ForwardHealth on the member's behalf. Providers are required to keep members informed of the PA request status throughout the **entire** PA process.

Member Questions

A member may call Member Services to find out whether or not a PA request has been submitted and, if so, when it was received by ForwardHealth. The member will be advised to contact the provider if more information is needed about the status of an individual PA request.

Topic #21279

Coordination of Care

For the initial PA (prior authorization) of an episode of care, providers are not required to submit documentation of coordination of care with SBS (school-based services) or community-based service providers for members under 21.

Providers are required to submit written attestation of coordination with SBS on subsequent PA requests when a member is receiving both community-based services and SBS in the same treatment discipline (for example, outpatient speech therapy and speech therapy in the school). This attestation must be documented on Element 16 of the PA/TA (Prior Authorization/Therapy Attachment, F-11008 (04/2025)), on the POC (plan of care), or on another document. Providers are required to maintain documentation of coordination of care in the member's medical record.

Providers are required to submit documentation of coordination of care with other community-based service providers on

subsequent PA requests.

Failure to coordinate care or to maintain documentation of coordination of care leading to duplicate services may result in denial of claims or recovery of funds.

Using PA Collaboratives to Coordinate Care

PA collaboratives can link two or more PA requests for the same member together so providers can easily see and maintain them. Providers can indicate that their PA request is part of a collaborative when they submit their PA request through the ForwardHealth Portal.

After successfully submitting a PA request to a PA collaborative, providers can view all PA requests within it. Through the PA Collaboration panel on the Portal, providers have the option to attest that the PA should remain in the collaborative or they may choose to opt out of the collaborative.

Topic #435

Definition

PA (Prior authorization) is the electronic or written authorization issued by ForwardHealth to a provider prior to the provision of a service. In most cases, providers are required to obtain PA **before** providing services that require PA. When granted, a PA request is approved for a specific period of time and specifies the type and quantity of service allowed.

Topic #5098

Designating an Address for Prior Authorization Correspondence

Correspondence related to PA (prior authorization) will be sent to the practice location address on file with ForwardHealth unless the provider designates a separate address for receipt of PA correspondence. This policy applies to all PA correspondence, including decision notice letters, returned provider review letters, returned amendment provider letters, and returned supplemental documentation such as X-rays and dental models.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

Providers may designate a separate address for PA correspondence using the demographic maintenance tool.

Topic #2795

Examples of Standards of Medical Necessity as Evaluated on Prior Authorization Requests

The following information and case examples are offered to illustrate how the standards of medical necessity, as defined in Wis. Admin. Code § DHS 101.03(96m), are applied when PT (physical therapy), OT (occupational therapy), or SLP (speech and language pathology) services are reviewed by ForwardHealth.

Per Wis. Admin. Code § DHS 101.03(96m), "medically necessary" means a medical service under ch. 107 that is:

(a) Required to prevent, identify or treat a member's illness, injury or disability; and

Example 1: Many members having the same diagnosis may have certain characteristics in common; however, the physical expression and functional severity of their conditions can vary greatly. As a result, documentation in the PA (prior authorization) request must include a medical diagnosis as well as a problem statement (treatment diagnosis) related to the medical diagnosis that identifies the specific treatment needs of the individual.

For example, physical therapy is requested for a four-year-old child with spastic diplegic cerebral palsy and a gross motor age equivalency of 44–48 months. A POC (plan of care) to address "continued development of age-appropriate mobility skills" would not meet the ForwardHealth application of this standard because no impairments, functional limitations, or disabilities have been identified. The reviewer would question how the requested service treats an illness, injury, or disability. If the therapist identified tight hamstrings but provided no evidence that hamstring contractures were causing any functional problems, the same questions remain.

If instead, the physical therapist's evaluation identified functional limitations including problems with climbing, frequent falls when walking from the bus to home, or other restrictions in outdoor mobility due to tight hamstrings, it may be appropriate to authorize a limited course of PT. In this case, PT may be necessary to improve dynamic range of motion and lower extremity strength, to facilitate functional skill acquisition, and to educate the member/caregivers on a home program including recommendations about when to seek medical attention for developing problems, such as worsening contractures.

Example 2: A nine-year-old is an independent household ambulator and presents with hypotonic trunk muscles. They have been receiving OT for the past six months. The new PA request includes continued treatment strategies of trunk elongation and rib cage mobilization with ongoing goals of preparing for strengthening/stability exercises and preventing frequent respiratory infections. No documentation of trunk range of motion, upper body strength testing, or frequency of respiratory infection is provided.

Measurable goals reflect treatment that is expected to reduce identified impairments and produce sustained changes in function and are necessary to describe how treatment will affect injury, illness, or disability. The medical necessity of the POC would be questioned because no deficits are reported, and no evidence is provided to support that soft tissue mobilization has resulted or would likely result in any sustainable change in the member's trunk control or any improvement in functional performance over time. The PA documentation does not support that a correlation exists between improving rib cage mobility and decreasing the member's susceptibility to respiratory infections. The PA request would be returned requesting this additional information.

Example 3: A PA is submitted for SLP services for a four-year-old child. The child only speaks at home and was referred by the family doctor for an SLP assessment. The standardized/non-standardized tests performed by the SLP provider indicate that the child's receptive and expressive language skills are age appropriate. The PA requests SLP services twice per week to improve the child's social language skills. In this situation, the ForwardHealth consultant may question if the services of an SLP provider are required, since the standardized tests indicate the child's language skills are age appropriate and do not identify an injury, illness, or disability potentially remediable by an SLP provider.

(b) Meets the following standards:

1. Is consistent with the member's symptoms, or with prevention, diagnosis or treatment of the member's illness, injury or disability;

Example 1: The client is a 35-year-old with cerebral palsy who is seven weeks post ankle fusion. Prior to surgery, they had been able to ambulate with a walker in their home. The PA request includes a PT POC to assess and/or teach transfer skills and evaluate orthotics and equipment needs. This POC reflects a situation where episodic therapy is warranted to maximize functional capacity following an orthopedic intervention. This PA request would be approved because it is consistent with treatment of the client's recent change in medical condition.

Example 2: A 16-year-old with a remote history of anoxic brain injury is dependent for all activities of daily living. An OT PA request is submitted to increase head control at midline from the member's current level of 3–5 seconds to 5–10 seconds. No progress has been documented in this area following extensive intervention to improve head control. When functional limitations persist for long periods and have not been remediable, compensatory strategies may be more appropriate. The PA request would be returned for additional information to support the benefit of continued direct treatment for improving head control as an effective or functional intervention.

Example 3: A PA is submitted for SLP services for a 45-year-old member diagnosed with intellectual disability, emotional disturbance, and seizure disorder. Their sheltered workshop supervisor referred the client for an SLP evaluation because over the past two months, both workshop staff and home caregivers have had difficulties understanding them due to decreased speaking rate and slurred speech. Upon assessment, the member's regression appears to coincide with the start of a new medication.

Without additional information, the ForwardHealth consultant would return the PA request questioning whether the member's decreased intelligibility may be related to the medication. Documentation of sufficient clinical information may then result in approval of SLP services for a brief episode of care to improve intelligibility.

2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;

Example: A PA request for sensory integration therapy is submitted for a nine-year-old with pervasive developmental disorder. Goals include decreased behavioral outbursts in natural environments like a noisy gym or shopping mall, improved sleeping patterns, and better ability to "self-regulate." The PA would be returned asking the provider to explain how skills learned in therapy would be generalized from the controlled environment of the clinic setting to the child's natural environment(s) of home or community. The ForwardHealth consultant may further question whether these issues would be more appropriately addressed by a behavioral therapist or through a consistent behavioral management home program.

3. Is appropriate with regard to generally accepted standards of medical practice;

Example 1: A PA is submitted with the therapist reporting that a member is "not testable" or with the majority of the therapy evaluation obtained from unstructured observation or from other sources. If the treating therapist is unable to establish a member's baseline functional skills and limitations, it will be impossible to later evaluate and document any changes that may result from therapeutic intervention. Initiating treatment without performing a comprehensive assessment that includes baseline measurements of the member's abilities and physical impairments is not appropriate with regard to generally accepted standards of practice. If a problem area is not or cannot be tested during the initial evaluation, it should be explained why data could not be obtained and that subsequent PAs will contain baseline data for reported problem areas as well as interval progress. This PA would be returned asking for additional information.

Example 2: An occupational therapist working with a child with a history of dysphagia submits a PA request with a goal for the child to tolerate a wider variety of foods. No clinical assessment of the child's oral motor/swallowing skills or results from a radiological swallow study have been documented to indicate that the proposed oral intake is safe. The PA request would be returned requesting this additional clinical information to assure that the treatment goals are appropriate.

4. Is not medically contraindicated with regard to the member's diagnoses, the member's symptoms or other medically necessary services being provided to the member;

Example 1: An 85-year-old is eight weeks post hip fracture with subsequent open reduction and internal fixation. The POC submitted with the PA includes goals of transferring with assistive device, achieving independence on stairs, and increasing unilateral weight bearing for improved balance, strength, and endurance while walking. No weight bearing restrictions or hip

precautions are included in the information submitted. In the absence of this standard medical information, the reviewer may question whether the goals are appropriate (or possibly contraindicated) depending on the recommended postoperative hip precautions. Also, the requested frequency or intensity of therapy may be inappropriate depending on the member's weight bearing status.

Example 2: For a member with the recent onset of dysphagia and a swallow study that indicates aspiration, an oral motor evaluation and initial course of treatment is medically necessary to see if swallowing abilities can be improved. If a subsequent request is submitted that indicates the member has been unable to maintain their weight with oral feedings or if clinical signs of aspiration such as cough or respiratory infection persist, then continued SLP services to address improving oral feeding skills without assessing the need for further dietary modifications (change in liquid/solid consistency) may be medically contraindicated. This PA would be returned for additional clinical information to support the safety of the requested therapy.

5. Is of proven medical value or usefulness and, consistent with Wis. Admin. Code § DHS 107.035, is not experimental in nature;

In assessing whether a service is experimental in nature, Wisconsin DHS (Department of Health Services) shall consider whether the service is a proven effective treatment for the condition for which it is intended or used, as evidenced by:

- The current and historical judgment of the medical community (as reflected by medical research, studies, or publications in peer-reviewed journals).
- The extent to which other health insurers provide coverage for the service.
- The current judgment of experts or specialists in the medical area for which the service is to be used.
- The judgment of the Wisconsin Medicaid Medical Audit Committee of the Wisconsin Medical Society or of any other committee that may be under contract to DHS as identified in Wisconsin Administrative Code.

The following interventions have been determined to be experimental: Facilitated Communication and Auditory Integration Therapy. The Wisconsin Medical Society has also determined that electrical stimulation for the treatment of open wounds can only be applied to Stage III or IV decubiti. Prior authorization for continued treatment is considered only if granulation tissue has formed or a 25 percent reduction in the affected area has occurred within 45 days of initiating electrical stimulation. Any PA request for electrical stimulation that falls outside these parameters is considered unproven and would be denied.

6. Is not duplicative with respect to other services being provided to the member;

Example 1: A 78-year-old with a diagnosis of Alzheimer's disease resides in a nursing home that specializes in the care of Alzheimer patients. The client transfers with moderate assistance and receives PT two times per week for gait training and to improve transfer skills. The member's transfer and ambulation skills have not progressed over the past month and the nursing staff has been instructed in safe transfer and ambulation techniques. The PT POC recommends continued PT services designed to maintain the member's abilities, stating that the member requires the skills of a therapist because they have Alzheimer's. Caregivers who have been properly instructed by a physical therapist regarding the member's unique set of problems should be skilled in working with this patient. Therefore, this PA request would be denied because it is duplicative to the member's maintenance care program.

Example 2: A child with autism is receiving intensive behavioral services with treatment goals of improved peer play, turn taking, sharing, and concentrating on conversation. The OT PA request includes goals for the child to participate in a group game following rules with proper sequencing and attention to task. The clinical intent of both services appears to be directed toward achieving the same outcome. Therefore, the PA request would be returned for clarification.

7. Is not solely for the convenience of the member, the member's family or a provider;

Example 1: A child with a history of traumatic brain injury receives PT services at school during the academic year. The IEP does not include recommendations for Extended School Year PT over the summer months. Physical therapy services are being

requested at a community-based clinic during the summer because, without therapy, the member's day lacks structured activities. Unless the services being requested require the professional skills of a therapist, the request may be viewed as an alternative to recreational or other community-based activities and appears to be submitted solely for convenience.

Example 2: An OT PA request is submitted to provide range of motion and strengthening. The member has skills that are sufficient to perform the program at home with supervision or in a community or recreational setting. In this case, the PA would be returned for additional information to explain why the skills of a therapist are required.

Example 3: A PA request is submitted for SLP services for a 38-year-old diagnosed with developmental delays. The member lives in a group home and communicates with an augmentative communication device. Previous therapy and product manuals have been provided for the member and caregivers to program and use the device. The PA requests SLP services for the purpose of creating a new communication page for the device. In this case, the Medicaid consultant would question if the service being requested is solely for convenience and if the member's caregiver or family member familiar with the device could create a new page.

8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the member; and

Example 1: A physical therapist has requested therapy services three times per week to work on a POC that is focused on repetition of skills to build endurance. A PA request for PT services at this frequency would be modified or denied. It would be more cost-effective for the client to work on building endurance through a home exercise program. Modification would allow the therapist to monitor the member's progress and to revise the home program as needed, instead of providing direct therapy to work on repetition of an already achieved skill. Programs that involve ongoing muscle strengthening and fitness often involve instructing the client to carry out activities independent of assistance or stressing recreational activities that encourage mobility and reinforce functional movement.

Example 2: An OT PA request is received to provide range of motion for a member who resides in a nursing home. A restorative nursing plan is in place and meets the functional needs of this individual. The therapy POC being requested does not include more advanced functional outcomes requiring the skills of a therapist. Occupational therapy services, in addition to restorative nursing, are not cost-effective and the PA request would be denied.

9. Is the most appropriate supply or level of service that can safely and effectively be provided to the member.

Example 1: A 10-year-old child with cerebral palsy has received many years of OT. Their current level of functional upper extremity dressing skills includes the ability to push their arm through their sleeve only when the shirt is held over their head and the sleeve is held in place for them. No volitional grasp or release is demonstrated. The OT POC is submitted for ongoing direct treatment to improve independent living skills. For this member, it appears that they reached a plateau, that no functional gains in upper extremity dressing skills can reasonably be anticipated, and that compensatory strategies and equipment are the most appropriate level of service that can be effectively provided. The direct skills of an occupational therapist may no longer be necessary at this time to maximize their functional performance. A more appropriate level of service may be provided by an occupational therapist on a consultative basis to monitor compensatory strategies and equipment and to evaluate further direct OT needs.

Example 2: A PA is submitted for SLP services to improve intelligibility in a 9-year-old child with a diagnosis of dyskinetic cerebral palsy. A review of the child's extensive therapy history indicates that there has been little functional improvement in the child's intelligibility. Standardized tests and subjective reporting also indicate that the child's intelligibility has not changed appreciably in three years despite receiving both school and community-based SLP services. The child has acquired an augmentative communication device to supplement their speech. In this situation, the Medicaid consultant would question if community-based SLP services focused on improving intelligibility remains the most appropriate level of service that can be

effectively provided to this member.

Topic #2733

Flexibility of Approved Services

ForwardHealth allows flexible use of approved, medically necessary PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) sessions so a provider may meet a member's needs.

ForwardHealth may approve a specific number of PT, OT, and SLP sessions that can be used flexibly. For example, rather than being restricted to providing PT, OT, and SLP services once a week for 10 weeks as approved on a PA (prior authorization) request, a provider and member may change the frequency of the sessions over the 10-week period. Therefore, PT, OT, and SLP services could be provided once a week for the first four weeks and twice a week **every other** week for the next six weeks.

The number of PT, OT, and SLP sessions used may not exceed the approved quantity and must be used between the PA grant and expiration dates.

Plan of Care Must Reflect Flexibility of Approved Services

ForwardHealth requires that the frequency and duration of PT, OT, and SLP services be written in the member's POC (plan of care) under Wis. Admin. Code §§ DHS 107.16, 107.17, and 107.18. To use the sessions flexibly, PT, OT, and SLP providers are required to have a physician's prescription that allows PT, OT, and SLP services to be used flexibly.

Note: Flexibility applies to all sessions approved on PAs including extension of therapy, maintenance therapy and SOI (spell of illness).

Duration of Approved Services

Prior authorization requests for PT, OT, and SLP services must meet the criteria of medically necessary under Wis. Admin. Code § DHS 101.03(96m).

In addition, the duration and frequency on a PA request should accurately reflect the POC.

If the PA request meets the criteria of medically necessary and the duration and frequency accurately reflect the POC, ForwardHealth should allow the following duration and number of sessions for PT, OT, and SLP services provided to individuals with **ongoing** treatment needs:

- Up to three sessions per week, for a duration of up to 26 weeks (maximum of 78 sessions)
- One or less than one therapy session per week, for a duration of up to 52 weeks (maximum of 52 sessions)

Duration applies for extension of therapy and maintenance therapy PAs but not SOI.

Coordinating Multiple PA Requests

ForwardHealth allows providers to request coordination of grant and expiration dates for the same member for multiple therapy disciplines. The intent of this provision is to increase coordinated planning by PT, OT, and SLP providers and enable members and their families to benefit from a coordinated service delivery plan. Providers can facilitate this process by consulting with other PT, OT, and SLP providers. ForwardHealth will respond to coordination requests when possible. Providers should request the same grant and expiration dates on each PA request and note that it is for coordination of care purposes.

When initiating PA coordination, providers may need to request shorter duration periods to synchronize the PA requests.

Using PA Collaboratives to Coordinate Multiple PA Requests

To facilitate coordination of care, providers can use PA collaboratives to link two or more PA requests for the same member together so providers can easily see and maintain them. Providers can indicate that their PA request is part of a collaborative when they submit their PA request through the ForwardHealth Portal.

After successfully submitting a PA request to a PA collaborative, providers can view all PA requests within it. Through the PA Collaboration panel on the Portal, providers have the option to attest that the PA should remain in the collaborative or they may choose to opt out of the collaborative.

Topic #2732

General Principles for Prior Authorization Requests

A PA (prior authorization) request for extension of therapy services, maintenance therapy services, or services that always require PA may be approved if the documentation provided establishes the following:

- Services are reasonably expected to be effective in achieving predictable and functional results for the member.
- Services are coordinated with the goals and activities of all other medical, educational, and vocational disciplines involved with the member.
- Services are cost-effective when compared with other available services that meet the member's treatment needs.
- Professional skills of a PT (physical therapy), OT (occupational therapy), or SLP (speech and language pathology) provider are required to meet the member's functional needs and therapy treatment needs.
- Treatment goals are reasonable given the member's current age and health status.
- Pertinent medical and social history is provided in sufficient detail to support that attainment of treatment goals would result in measurable and sustained benefit to the member.
- Frequency and duration of the requested services are based on the estimated length of time required for the member to realistically achieve the treatment goals.
- Medical diagnosis and problem statement (treatment diagnosis) identify the specific treatment needs of the member.
- Progress statements are objective, measurable, and demonstrate the desired outcome from the PT, OT, or SLP services in terms of functional improvements that can be generalized to settings outside the immediate treatment environment.
- Short-term objectives are realistic and attainable by the end of the requested PA.
- Long-term objectives describe the predicted functional changes expected by the end of the episode of care (not necessarily at the end of the requested PA).
- A plan to educate the member or caregiver and transition responsibility of the PT, OT, or SLP program is created, including an HEP (home exercise program).

Topic #2731

Medical Necessity

ForwardHealth relies on its definition of medically necessary, as stated in Wis. Admin. Code § DHS 101.03(96m), to determine whether a particular service may be reimbursed by Wisconsin Medicaid. Medical necessity for PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services is focused on intervention activities that are designed to produce specific outcomes.

ForwardHealth uses the PA (prior authorization) process to determine whether the standards of medical necessity are met and to assure that appropriate PT, OT, and SLP services are provided to members. ForwardHealth consultants evaluate PA requests for PT, OT, and SLP services on a case-specific basis. A PA request may be approved only if the documentation submitted in the

PA request establishes that the standards of medical necessity, in addition to all other program requirements, are met.

Common reasons for finding a "lack of medical necessity" include the following:

- Baseline performance is not documented in terms of the member's current functional abilities and limitations.
- Clinical information is not provided in sufficient detail to suggest that both of the following are true:
  - Treatment goals are reasonable given the current age and health status of the member.
  - Attainment of treatment goals would result in predictable functional improvement to the member.
- Documentation fails to support that the professional skills of a PT, OT, or SLP provider are required to meet the member's functional needs and therapy treatment needs.
- The member has failed to make progress toward the targeted goals and objectives in a reasonable time period, and the PT, OT, or SLP provider has not modified the treatment plan or objectives in spite of the anticipated outcomes not being achieved.

Relationship of Medical Necessity to Clinical Practice Principles

PT, OT, or SLP services reimbursed by Wisconsin Medicaid reflect the following principles of clinical practice:

- An intervention plan should not be based solely on the presence of a medical diagnosis.
- Frequency or duration of treatment is determined by rate of change as a result of therapy, rather than level of severity.[1]
- Decisions about direct service intervention are contingent on timely monitoring of patient or client response and progress made toward achieving the anticipated goals and expected outcomes.[2]
- The need for the service has been determined in collaboration with the primary caregivers and others working together on behalf of the individual.
- Families or caregivers affect the priorities for intervention through their direct and proactive participation in the therapeutic process and should be encouraged to participate in all treatment decisions.
- Intervention is unlikely to promote lasting functional improvements if the only opportunity to develop new skills occurs during sessions with the therapist.
- Therapeutic intervention strategies include an educational focus and home program that enables the family or caregiver and eventually the individual to facilitate and reinforce long-term gains.

[1] American Occupational Therapy Association.

[2] Guide to Physical Therapist Practice, 2001 American Physical Therapy Association, p. 38 and 46.

Topic #4383

Prior Authorization Numbers

Upon receipt of the PA/RF (Prior Authorization Request Form, F-11018 (05/2013)), ForwardHealth will assign a PA (prior authorization) number to each PA request.

The PA number consists of 10 digits, containing valuable information about the PA (for example, the date the PA request was received by ForwardHealth, the medium used to submit the PA request).

Each PA request is assigned a unique PA number. This number identifies valuable information about the PA. The following table provides detailed information about interpreting the PA number.

Type of Number and Description	Applicable Numbers and Description
Media—One digit indicates media type.	Digits are identified as follows:

	1 = paper; 2 = fax; 3 = STAT-PA (Specialized Transmission Approval Technology-Prior Authorization); 4 = STAT-PA; 5 = Portal; 6 = Portal; 7 = NCPDP (National Council for Prescription Drug Programs) transaction or 278 (278 Health Care Services Review—Request for Review and Response) transaction; 9 = eviCore healthcare
Year—Two digits indicate the year ForwardHealth received the PA request.	For example, the year 2008 would appear as 08.
Julian date—Three digits indicate the day of the year, by Julian date, that ForwardHealth received the PA request.	For example, February 3 would appear as 034.
Sequence number—Four digits indicate the sequence number.	The sequence number is used internally by ForwardHealth.

Topic #436

Reasons for Prior Authorization

Only about 4% of all services covered by Wisconsin Medicaid require PA (prior authorization). PA requirements vary for different types of services. Refer to ForwardHealth publications and Wis. Admin. Code ch. DHS 107 for information regarding services that require PA. According to Wis. Admin. Code § DHS 107.02(3)(b), PA is designed to:

- Safeguard against unnecessary or inappropriate care and services.
- Safeguard against excess payments.
- Assess the quality and timeliness of services.
- Promote the most effective and appropriate use of available services and facilities.
- Determine if less expensive alternative care, services, or supplies are permissible.
- Curtail misutilization practices of providers and members.

PA requests are processed based on criteria established by Wisconsin DHS (Department of Health Services).

Providers should not request PA for services that do not require PA simply to determine coverage or establish a reimbursement rate for a manually priced procedure code. Also, new technologies or procedures do not necessarily require PA. PA requests for services that do not require PA are typically returned to the provider. Providers having difficulties determining whether or not a service requires PA may call Provider Services.

Topic #437

Referrals to Out-of-State Providers

PA (prior authorization) may be granted to out-of-state providers when nonemergency services are necessary to help a member attain or regain their health and ability to function independently. The PA request may be approved only when the services are not reasonably accessible to the member in Wisconsin.

Out-of-state providers are required to meet ForwardHealth's guidelines for PA approval. This includes sending PA requests, required attachments, and supporting documentation to ForwardHealth before the services are provided.

Note: Emergency services provided out-of-state do not require PA; however, claims for such services must include appropriate documentation (for example, anesthesia report, medical record) to be considered for reimbursement. Providers are required to

submit claims with supporting documentation on paper.

When a Wisconsin Medicaid provider refers a member to an out-of-state provider, the referring provider should instruct the out-of-state provider to go to the Provider Enrollment Information home page on the ForwardHealth Portal to complete a Medicaid Out-of-State Provider Enrollment Application.

All out-of-state nursing homes, regardless of location, are required to obtain PA for all services. All other out-of-state nonborder-status providers are required to obtain PA for all nonemergency services except for home dialysis supplies and equipment.

Topic #438

Reimbursement Not Guaranteed

Wisconsin Medicaid may decline to reimburse a provider for a service that has been prior authorized if one or more of the following program requirements is not met:

- The service authorized on the approved PA (prior authorization) request is the service provided.
- The service is provided within the grant and expiration dates on the approved PA request.
- The member is eligible for the service on the date the service is provided.
- The provider is enrolled in Wisconsin Medicaid on the date the service is provided.
- The service is billed according to service-specific claim instructions.
- The provider meets other program requirements.

Providers may not collect payment from a member for a service requiring PA under any of the following circumstances:

- The provider failed to seek PA before the service was provided.
- The service was provided before the PA grant date or after the PA expiration date.
- The provider obtained PA but failed to meet other program requirements.
- The service was provided before a decision was made, the member did not accept responsibility for the payment of the service before the service was provided, and the PA was denied.

There are certain situations when a provider may collect payment for services in which PA was denied.

Other Health Insurance Sources

Providers are encouraged, but not required, to request PA from ForwardHealth for covered services that require PA when members have other health insurance coverage. This is to allow payment by Wisconsin Medicaid for the services provided in the event that the other health insurance source denies or recoups payment for the service. If a service is provided before PA is obtained, ForwardHealth will not consider backdating a PA request solely to enable the provider to be reimbursed.

Topic #1268

Sources of Information

Providers should verify that they have the most current sources of information regarding PA (prior authorization). It is critical that providers and staff have access to these documents:

- Wisconsin Administrative Code: Chapters DHS 101 through DHS 109 are the rules regarding Medicaid administration.
- Wisconsin Statutes: Sections 49.43 through 49.99 provide the legal framework for Wisconsin Medicaid.
- ForwardHealth Portal: The Portal gives the latest policy information for all providers, including information about Medicaid managed care enrollees.

Topic #812

Status Inquiries

Providers may inquire about the status of a PA (prior authorization) request through one of the following methods:

- Accessing WiCall, ForwardHealth's AVR (Automated Voice Response) system
- Calling Provider Services

Providers should have the 10-digit PA number available when making inquiries.

Grant and Expiration Dates

Topic #21277

Backdating

ForwardHealth will backdate OT (occupational therapy), PT (physical therapy), and SLP (speech and language pathology) PA (prior authorization) and SOI (spell of illness) requests that are received within 14 calendar days of the requested start date of the PA or SOI.

Topic #440

Expiration Date

The expiration (end) date of an approved or modified PA (prior authorization) request is the date through which services are prior authorized. PA requests are granted for varying periods of time. Expiration dates may vary and do not automatically expire at the end of the month or calendar year. In addition, providers may request a specific expiration date. Providers should carefully review all approved and modified PA requests and make note of the expiration dates.

Topic #441

Grant Date

The grant (start) date of an approved or modified PA (prior authorization) request is the first date in which services are prior authorized and will be reimbursed under this PA number. On a PA request, providers may request a specific date that they intend services to begin. If no grant date is requested or the grant date is illegible, the grant date will typically be the date the PA request was reviewed by ForwardHealth.

Submission Options

Topic #12597

278 Health Care Services Review — Request for Review and Response Transaction

Providers may request PA (prior authorization) electronically using the 278 (278 Health Care Services Review — Request for Review and Response) transaction, the standard electronic format for health care service PA requests.

Compliance Testing

Trading partners may conduct compliance testing for the 278 transaction.

After receiving an "accepted" 999 (999 Functional Acknowledgment) for a test 278 transaction, trading partners are required to call the EDI (Electronic Data Interchange) Helpdesk to request the production 278 transaction set be assigned to them.

Submitting Prior Authorization Requests

Submitting an initial PA request using the 278 transaction does not result in a real-time approval and cannot be used to request PA for drugs and diabetic supplies.

After submitting a PA request via a 278 transaction, providers will receive a real-time response indicating whether the transaction is valid or invalid. If the transaction is invalid, the response will indicate the reject reason(s), and providers can correct and submit a new PA request using the 278 transaction. A real-time response indicating a valid 278 transaction will include a PA number and a pending status. The PA request will be placed in a status of "Pending - Fiscal Agent Review."

The 278 transaction does not allow providers to submit supporting clinical information as required to adjudicate the PA request.

Trading partners cannot submit the 278 transaction through PES (Provider Electronic Solutions). In order to submit the 278 transaction, trading partners will need to use their own software or contract with a software vendor.

Topic #455

Fax

Faxing of all PA (prior authorization) requests to ForwardHealth may eliminate one to three days of mail time. The following are recommendations to avoid delays when faxing PA requests:

- Providers should follow the PA fax procedures.
- Providers should **not** fax the same PA request more than once.
- Providers should **not** fax **and** mail the same PA request. This causes delays in processing.

PA requests containing X-rays, dental molds, or photos as documentation must be mailed; they may not be faxed.

To help safeguard the confidentiality of member health care records, providers should include a fax transmittal form containing a confidentiality statement as a cover sheet to all faxed PA requests. The Prior Authorization Fax Cover Sheet (F-01176

(09/2022)) includes a confidentiality statement and may be photocopied.

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

Prior Authorization Fax Procedures

Providers may fax PA requests to ForwardHealth at 608-221-8616. PA requests sent to any fax number other than 608-221-8616 may result in processing delays.

When faxing PA requests to ForwardHealth, providers should follow the guidelines/procedures listed below.

Fax Transmittal Cover Sheet

The completed fax transmittal cover sheet must include the following:

- Date of the fax transmission
- Number of pages, including the cover sheet (The ForwardHealth fax clerk will contact the provider by fax or telephone if all the pages do not transmit.)
- Provider contact person and telephone number (The ForwardHealth fax clerk may contact the provider with any questions about the fax transmission.)
- Provider number
- Fax telephone number to which ForwardHealth may send its adjudication decision
- To: "ForwardHealth Prior Authorization"
- ForwardHealth's fax number at 608-221-8616 (PA requests sent to any other fax number may result in processing delays.)
- ForwardHealth's telephone numbers

For specific PA questions, providers should call Provider Services.

Incomplete Fax Transmissions

If the pages listed on the initial cover sheet do not all transmit (pages stuck together, the fax machine has jammed, or some other error has stopped the fax transmission), or if the PA request is missing information, providers will receive the following by fax from the ForwardHealth fax clerk:

- A cover sheet explaining why the PA request is being returned.
- Part or all of the original incomplete fax that ForwardHealth received.

If a PA request is returned to the provider due to faxing problems, providers should do the following:

- Attach a completed cover sheet with the number of pages of the fax.
- Resend the entire original fax transmission and the additional information requested by the fax clerk to 608-221-8616.

General Guidelines

When faxing information to ForwardHealth, providers should not reduce the size of the PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) or the PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (05/13)) to fit on the bottom half of the cover page. This makes the PA request difficult to read and leaves no space for consultants to write a response if needed or to sign the request.

If a photocopy of the original PA request and attachments is faxed, the provider should make sure these copies are clear and legible. If the information is not clear, it will be returned to the provider.

If the provider does not indicate his or her fax number, ForwardHealth will mail the decision back to the provider.

ForwardHealth will attempt to fax a response to the PA request to a provider three times. If unsuccessful, the PA request will be mailed to the provider.

If providers are not sure if an entire fax was sent, they should call ForwardHealth's fax clerk at 608-224-6124, to inquire about the status of the fax.

Prior Authorization Request Deadlines

Faxing a PA request eliminates one to three days of mail time. However, the adjudication time of the PA request has not changed. All actions regarding PA requests are made within the predetermined time frames.

Faxed PA requests received after 1 p.m. will be considered as received the following business day. Faxed PA requests received on a Saturday, Sunday, or holiday will be processed on the next business day.

Avoid Duplicating Prior Authorization Requests

After faxing a PA request, providers should not send the original paperwork by mail. Mailing the original paperwork after faxing the PA request will create duplicate PA requests in the system and may result in a delay of several days to process the faxed PA request.

Refaxing a PA request before the previous PA request has been returned will also create duplicate PA requests and may result in delays.

Response Back from ForwardHealth

Once ForwardHealth reviews a PA request, ForwardHealth will fax one of three responses back to the provider:

- "Your approved, modified, or denied PA request(s) is attached."
- "Your PA request(s) requires additional information (see attached). Resubmit the entire PA request, including the attachments, with the requested additional information."
- "Your PA request(s) has missing pages and/or is illegible (see attached). Resubmit the entire PA request, including the attachments."

Resubmitting Prior Authorization Requests

When resubmitting a faxed PA request, providers are required to resubmit the faxed copy of the PA request, including attachments. This will allow the provider to obtain the earliest possible grant date for the PA request (apart from backdating for retroactive enrollment). If any attachments or additional information that was requested is received without the rest of the PA request, the information will be returned to the provider.

Topic #458

ForwardHealth Portal Prior Authorization

Providers can use the PA (prior authorization) features on the ForwardHealth Portal to do the following:

- Submit PA requests and amendments for all services that require PA.
- View or maintain a PA collaboration (for certain services only).
- Save a partially completed PA request and return at a later time to finish completing it.

- Submit a letter seeking to extend an incomplete PA request.
- Upload PA attachments and additional supporting clinical documentation for PA requests.
- Receive decision notice letters and returned provider review letters.
- Correct returned PA requests and PA amendment requests.
- Change the status of a PA request from "Suspended" to "Pending."
- Submit additional supporting documentation for a PA request that is in "Suspended" or "Pending" status.
- Search and view previously submitted PA requests or saved PA requests.
- Print a PA cover sheet.

Submitting PA Requests and Amendment Requests

Providers can submit PA requests for all services that require PA to ForwardHealth via the secure Provider area of the Portal. To save time, providers can copy and paste information from plans of care and other medical documentation into the appropriate fields on the PA request. Except for those providers exempt from NPI (National Provider Identifier) requirements, NPI and related data are required on PA requests submitted via the Portal.

When completing PA attachments on the Portal, providers can take advantage of an Additional Information field at the end of the PA attachment that holds up to five pages of text that may be needed.

Providers may also submit amendment requests via the Portal for PA requests with a status of "Approved" or "Approved with Modifications."

View or Maintain a PA Collaboration (for Certain Services Only)

A **PA collaborative** will link two or more PA requests for the same member together so providers can easily see and maintain them. Providers may collaborate on PA request submissions and amendments that are submitted for certain services through the Portal.

Any of the following provider types may initiate or add a PA request to a collaborative:

- Physical therapists
- Occupational therapists
- Speech-language pathologists
- Home health agencies
- Personal care agencies

PA requests and amendments will continue to be reviewed individually, regardless of whether they are part of a PA collaborative or not. The denial or modification of one PA request will **not** impact other PA requests in the same collaborative.

Saving Partially Completed PA Requests

Providers do not have to complete PA requests in one session; they can save partially completed PA requests at any point after the Member Information page has been completed by clicking on the Save and Complete Later button, which is at the bottom of each page. There is no limit to how many times PA requests can be saved.

Providers can complete partially saved PA requests at a later time by logging in to the secure Provider area of the Portal, navigating to the Prior Authorization home page, and clicking on the Complete a Saved PA Request link. This link takes the provider to a Saved PA Requests page containing all of the provider's PA requests that have been saved.

Once on the Saved PA Requests page, providers can select a specific PA request and choose to either continue completing it or delete it.

Note: The ability to save partially completed PA requests is only applicable to new PA requests. Providers cannot save partially completed PA amendments or corrections to returned PA requests or amendments.

30 Calendar Days to Submit or Re-Save PA Requests

Providers must submit or re-save PA requests within 30 calendar days of the date the PA request was last saved. After 30 calendar days of inactivity, a PA request is automatically deleted, and the provider has to re-enter the entire PA request.

The Saved PA Requests page includes a list of deleted PA requests. This list is for information purposes only and includes saved PA requests that have been deleted due to inactivity (it does **not** include PA requests deleted by the provider). Neither providers nor ForwardHealth are able to retrieve PA requests that have been deleted.

Extending PA Requests

If a provider needs more than 30 days to submit the requested information, providers can request an extension by submitting a letter that explains why more time is needed to gather and submit the additional information requested. The letter seeking an extension must be submitted within the initial 30 calendar days of receiving the returned provider review letter.

Instructions for how to submit the letter can be found in the ForwardHealth Provider Portal Prior Authorization User Guide. If a provider wants to submit the letter via mail or fax, the provider must ensure it is received within the 30 days. While mailed or faxed letters are accepted, providers are encouraged to submit the letter via electronic upload.

Providers will be notified in a manner similar to how they submitted their letter, and the new deadline will be included in that notification. Providers who mail their submissions will receive a notification in the mail. Providers who electronically upload their submission will receive a notification in the Portal, etc.

Submitting Completed PA Requests

ForwardHealth's initial receipt of a PA request occurs when the PA request is submitted on the Portal. Normal backdating policy applies based on the date of initial receipt, not on the last saved date. Providers receive a confirmation of receipt along with a PA number once a PA request is submitted on the Portal.

PA Attachments on the Portal

Almost all PA request attachments can be completed and submitted on the Portal. When providers are completing PA requests, the Portal presents the necessary attachments needed for that PA request. For example, if a physician is completing a PA request for physician-administered drugs, the Portal will prompt a PA/PAD (Prior Authorization/Physician-Administered Drug Attachment, F-11034 (07/2022)) and display the form for the provider to complete. Certain PA attachments cannot be completed online or uploaded.

Providers may also upload an electronically completed version of the paper PA attachment form. However, when submitting a PA attachment electronically, ForwardHealth recommends completing the PA attachment online as opposed to uploading an electronically completed version of the paper attachment form to reduce the chances of the PA request being returned for clerical errors.

All PA request attachment forms are available on the Portal to download and print to submit by fax or mail.

Providers may also choose to submit their PA request on the Portal and mail or fax the PA attachment(s) and/or additional supporting documentation to ForwardHealth. If the PA attachment(s) are mailed or faxed, a system-generated Portal PA Cover Sheet (F-11159 (07/12)) must be printed and sent with the attachment to ForwardHealth for processing. Providers must list the attachment(s) on the Portal PA Cover Sheet. When ForwardHealth receives the PA attachment(s) by mail or fax, they will be matched up with the PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) that was completed on the Portal.

Note: If the cover sheet could not be generated while submitting the PA request due to technical difficulties, providers can print the cover sheet from the main Portal PA page.

Before submitting any PA request documents, providers should save or print a copy for their records. Once the PA request is submitted, it cannot be retrieved for further editing.

As a reminder, ForwardHealth does not mail back any PA request documents submitted by providers.

Additional Supporting Clinical Documentation

ForwardHealth accepts additional supporting clinical documentation when the information cannot be indicated on the required PA request forms and is pertinent for processing the PA request or PA amendment request. Providers have the following options for submitting additional supporting clinical information for PA requests or PA amendment requests:

- Upload electronically
- Mail
- Fax

Providers can choose to upload electronic supporting information through the Portal in the following formats:

- JPEG (.jpg or .jpeg)
- PDF (.pdf)
- Rich Text Format (.rtf)
- Text File (.txt)
- OrthoCAD (.3dm) (for dental providers)

JPEG files must be stored with a ".jpg" or ".jpeg" extension; text files must be stored with a ".txt" extension; rich text format files must be stored with an ".rtf" extension; and PDF files must be stored with a ".pdf" extension. Dental OrthoCAD files are stored with a ".3dm" extension.

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

In addition, providers can also upload additional supporting clinical documentation via the Portal when:

- Correcting a PA request or PA amendment request that is in a "Returned — Provider Review" status.
- Submitting a PA amendment request.

If submitting supporting clinical information via mail or fax, providers are prompted to print a system-generated Portal PA Cover Sheet to be sent with the information to ForwardHealth for processing. Providers must list the additional supporting information on the Portal PA Cover Sheet.

ForwardHealth will return PA requests and PA amendments requests when the additional documentation could have been indicated on the PA/RF and PA attachments or when the pertinent information is difficult to find.

"Suspended" PA Requests

For PA requests in a "Suspended" status, the provider has the option to:

- Change a PA request status from "Suspended" to "Pending."
- Submit additional documentation for a PA request that is in "Suspended" or "Pending" status.

Changing a PA Request From "Suspended" to "Pending"

The provider has the option of changing a PA request status from "Suspended — Provider Sending Info" to "Pending" if the provider determines that additional information will not be submitted. Changing the status from "Suspended — Provider Sending Info" to "Pending" will allow the PA request to be processed without waiting for additional information to be submitted. The provider can change the status by searching for the suspended PA request, checking the box indicating that the PA request is ready for processing without additional documentation, and clicking the Submit button to allow the PA request to be processed by ForwardHealth. There is an optional free form text box, which allows providers to explain or comment on why the PA request can be processed.

Submitting Additional Supporting Clinical Documentation for a PA Request in "Suspended" or "Pending" Status

There is an Upload Documents for a PA link on the PA home page in the provider secured Home Page. By selecting that link, providers have the option of submitting additional supporting clinical documentation for a PA request that is in "Suspended" or "Pending" status. When submitting additional supporting clinical documentation for a PA request that is in "Suspended" status, providers can choose to have ForwardHealth begin processing the PA request or to keep the PA request suspended. PA requests in a "Pending" status are processed regardless.

Note: When the PA request is in a "Pending" status and the provider uploads additional supporting clinical documentation, there may be up to a four-hour delay before the documentation is available to ForwardHealth in the system. If the uploaded information was received after the PA request was processed and the PA request was returned for missing information, the provider may resubmit the PA request stating that the missing information was already uploaded.

Topic #22397

Submitting PA Requests for Physical Therapy, Occupational Therapy, and Speech and Language Pathology Through the Portal for Real-Time Review and Approval

PA requests for process types 111 (physical therapy), 112 (occupational therapy), and 113 (speech and language pathology) for members under age 6 that are submitted through the ForwardHealth Portal may be granted real-time review and approval. If the member is age 6 or older, the provider will be directed to the standard PA request submission process.

In **real-time review** on the Portal, when the PA request is submitted, it is either approved at the point of submission or sent to a consultant for manual review. PA requests are not denied during real-time review. PA requests for PT (physical therapy), OT (occupational therapy), or SLP (speech and language pathology) may receive real-time PA review and approval through the Portal if all of the applicable PA criteria are met. In accordance with Wis. Admin Code § DHS 107.02(3), there may be instances in which a provider or member is not eligible for real-time PA review and approval, in which case the provider will be notified that the PA request will be manually reviewed by a consultant. PA requests may be denied during manual review if PA approval criteria are not met.

For real-time PA review and approval, all required documentation must be uploaded or entered at the point of PA submission via the Portal. Once a provider receives confirmation of real-time approval for a PA request for PT, OT, or SLP through the Portal, no further action is necessary to complete the PA request.

These are examples of situations that would make a PA request for PT, OT, or SLP ineligible for real-time PA review:

- Required fields on PA forms are not completed.
- Required PA attachments are not submitted.
- The PA request does not meet the criteria for real-time PA review.
- The member is not eligible due to age or effective eligibility dates.

Topic #22417

Prior Authorization Collaboratives

A **PA (prior authorization) collaborative** will link two or more PA requests for the same member together so providers can easily see and maintain them.

Any of the following provider types may initiate or add a PA request to a collaborative:

- Physical therapists
- Occupational therapists
- Speech-language pathologists
- Home health agencies
- Personal care agencies

A provider can indicate their PA request is part of a PA collaborative when submitting their request through the ForwardHealth Portal.

Submissions to PA Collaboratives on the Portal

Providers can submit a PA request as part of a new or existing collaborative on the Portal. The Portal will then assign a nine-digit ID number that the initiating provider can share with collaborating providers. The collaborating providers will use the collaborative ID number to associate their own PA request with the collaborative.

PA collaboratives are available for the following process types for PA requests submitted through the Portal:

- 111–PT (physical therapy)
- 112–OT (occupational therapy)
- 113–SLP (speech and language pathology)
- 114–SOI (spell of illness) for PT
- 115–SOI for OT
- 116–SOI for SLP
- 120–Home care
- 120–Home health therapy
- 121–Personal care services

Note: Providers that select process type 120 for private duty nursing or process type 142 for behavioral treatment should select None in the Provider Collaboration section of the Initial Information panel when submitting their PA requests through the Portal. If a provider selects New Collaborative or Existing Collaborative in the Provider Collaboration section of the Initial Information panel, ForwardHealth will return the PA request to the provider to resubmit.

After successfully submitting a PA request to a PA collaborative, providers can view all PA requests within it. Through the PA Collaboration panel on the Portal, providers have the option to attest that the PA should remain in the collaborative or they may choose to opt out of the collaborative.

PA requests and amendments will continue to be reviewed individually, regardless of whether they are part of a PA collaborative or not. The denial or modification of one PA request will **not** impact other PA requests in the same collaborative.

Providers can remove their own PA requests without ending the collaborative if two or more PA requests remain in the collaborative.

All PA requests in a PA collaborative must have start and end dates within the date range of the PA collaborative. If only one PA request remains in the collaborative, the provider must opt out of the collaborative to submit their PA request independently, unless another PA request is added. Providers should refer to the ForwardHealth Provider Portal Prior Authorization User Guide for step-by-step instructions on navigating the Portal for PA collaboratives.

If a provider submits a PA request to be added to an existing PA collaborative, but the collaborative has already been submitted through the Portal, then the provider will get the following message displayed on their screen:

> "The Collaborative ID has been submitted and additional PAs may not be added in the WIPortal. Please use the PA Amendment Process to have the PA added to the PA Collaborative ID."

Real-Time Review and Approval Not Available for PA Collaboratives

Certain PT, OT, and SLP, and personal care services are able to access real-time PA review. At this time, the real-time PA review is **not** available for PA collaboratives or the PAs they contain.

Topic #456

Mail

Any type of PA (prior authorization) request may be submitted on paper. Providers may mail completed PA requests, amendments to PA requests, and requests to enddate a PA request to ForwardHealth at the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

Requesting Spell of Illness

Topic #8677

Backdating

ForwardHealth will backdate OT (occupational therapy), PT (physical therapy), and SLP (speech and language pathology) SOI (spell of illness) requests that are received within 14 calendar days of the requested start date of the SOI.

Topic #18617

Examples of Conditions for Physical, Occupational, and Speech Therapy Spell of Illness Approval by Category

The following table includes examples of conditions that could meet ForwardHealth's criteria to qualify for SOI (spell of illness) approval and should be used as an aid for selecting the qualifying statement that most accurately reflects the member's condition. These examples are not intended as diagnosis suggestions; all diagnosis or procedure codes entered on the PA/SOIA (Prior Authorization/Spell of Illness Attachment, F-11039 (10/2015)) should use the proper ICD (International Classification of Diseases) code and description. This table is **not** exhaustive; some conditions that qualify for SOI approval may not be listed.

Examples of Conditions for Physical, Occupational, and Speech Therapy Spell of Illness Approval by Category

Category	Physical Therapy	Occupational Therapy	Speech Therapy
Neuromuscular disease, injury, or condition	Amyotrophic lateral sclerosis CVA (cerebral vascular accident) Cauda equina syndrome Cervicalgia Diabetes mellitus Disorders of cranial nerves Encephalopathy Guillan-Barre syndrome Head injury Hemiplegia and hemiparesis Huntington's chorea and other choreas Malignant neoplasm Meningitis MS (multiple sclerosis) Neuralgias, Nerve root and plexus disorders Parkinson's disease	Amyotrophic lateral sclerosis CVA Diabetes mellitus Disorders of cranial nerves Encephalopathy Guillan-Barre syndrome Head injury Hemiplegia and hemiparesis Huntington's chorea and other choreas Malignant neoplasm Meningitis MS Neuralgias, Nerve root and plexus disorders Parkinson's disease	Amyotrophic lateral sclerosis Aneurysm Aphasia Bell's Palsy Brain injury Cerebral cysts, edema, embolism, laceration, and contusion Compression of brain Disorders of cranial nerves Encephalopathy Epilepsy Facial nerve disorders Guillan-Barre syndrome Huntington's chorea Malignant neoplasm Meningitis Motor Neuron disease

			MS Parkinson's disease
Musculoskeletal disease, injury, or condition	Amputation Arthroplasty Disorders of synovium, tendon, and bursa Fracture (traumatic and pathologic) Gouty arthropathy Internal derangement of knee Intervertebral disc disorders Joint replacement Kyphoscolisis and scoliosis Osteoarthritis RA (rheumatoid arthritis) Spinal fusion Sprains and strains of joints and adjacent muscles TMJ (temporomandibular joint) disorders	Amputation Arthroplasty Disorders of synovium, tendon, and bursa Dupuytren's contracture Fracture (traumatic and pathologic) Gouty arthropathy Joint replacement Osteoarthritis RA Sprains and strains of joints and adjacent muscles Trigger finger	Benign neoplasm of lip, oral cavity, and pharynx Cellulitis and perichondritis of larynx Cleft lip and palate/repair Polyps and nodules of vocal cords or larynx Swelling mass or lump in head and neck
Physiologic disease, injury, or condition	Benign paroxysmal positional vertigo Epilepsy Gangrene Headache HIV (human immunodeficiency virus) infection Lymphedema Meniere's disease Orthostatic hypotension Reflex sympathetic dystrophy Sickle-cell anemia Systemic lupus erythematosus	Epilepsy HIV infection Lymphedema Post-mastectomy lymphedema Sickle-cell anemia	Epilepsy Polyps and nodules of vocal cords and larynx
Exacerbation of pre-existing condition	Juvenile chronic polyarthritis Lymphedema Motor neuron disease (incl. Amyotrophic lateral sclerosis) MS Parkinson's disease	Juvenile chronic polyarthritis Lymphedema Motor neuron disease (incl. Amyotrophic lateral sclerosis) MS Parkinson's disease	Diffuse diseases of connective tissue Facial nerve disorders Hemiplegia and hemiparesis Head injury MS

	RA	RA	Myasthenia gravis Other choreas Paralysis of vocal cords or larynx Late effects of cerebrovascular disease
Regression in condition due to lack of therapy	Anoxic brain damage Contracture of joint Encephalopathy, unspecified Toxic encephalopathy MS Muscular dystrophy	Contracture of joint Encephalopathy, unspecified Toxic encephalopathy MS Muscular dystrophy	Encephalopathy MS Muscular dystrophy

Topic #2801

Maximum Allowable Dates of Service

The allowable DOS (dates of service) that may be granted for each SOI (spell of illness) subsequent to the initial SOI is 20 days to be used over the SOI term of six months. If more DOS are required, the provider may request additional DOS by amending the current approved or modified PA (prior authorization) request without submitting a new PA request.

Topic #18619

Prior Authorization Amendments

Providers are required to use the Prior Authorization Amendment Request (F-11042 (07/2012)) to request an amendment. Providers may submit an amendment to a current PA (prior authorization) request to change any of the following information:

- The rendering provider information when the billing provider remains the same
- The member's ForwardHealth identification number
- The grant or expiration date(s)
- The specific treatment code(s)
- The number of DOS (dates of service) authorized

If additional DOS are required to complete the POC (plan of care), and therapy is expected to be completed within 30 days of the current expiration date, a provider may submit a Prior Authorization Amendment Request with the following documentation:

- The reason why the POC could not be completed within the number of DOS granted.
- The number of additional DOS requested.
- The specific, objective measurements of the progress toward functional goals the member has achieved from therapy already provided.
- Any other clinical information to justify on-going, skilled therapy services.

Topic #2800

Requirements

When submitting the PA/SOIA (Prior Authorization/Spell of Illness Attachment, F-11039 (10/2015)), providers are required to select one of the five statements about the member's diagnosis or condition and answer "yes" or "no" to the statement, "The member displays the potential to re-achieve the skill level that he or she had previously." ForwardHealth uses the answers to these statements to determine if the SOI (spell of illness) request will be approved. If the PA request is approved, the SOI will be granted for a duration of up to six months with a maximum of 20 DOS (dates of service).

A PA (prior authorization) request for an SOI may be approved if all of the following are true:

- Only one of the five statements from Element 12 of the PA/SOIA is selected. If the member's condition could be categorized by more than one of the statements, providers should choose the statement that best describes the reason for the SOI.
- There is a reasonable expectation that the member will return to his or her previous level of function by the end of this SOI or sooner.

If these conditions are not met, ForwardHealth will return the PA request and instruct the provider to use the PA/TA (Prior Authorization/Therapy Attachment, F-11008 (04/2025)).

Extension of Therapy vs. Spell of Illness

Topic #2741

Extension of Therapy Services Encouraged

PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) providers are encouraged to request an extension of therapy services (instead of SOI (spell of illness)) when either of the following is true:

- The provider is unsure if the member has received, or is currently receiving, PT, OT, or SLP services from another provider for the current SOI.
- The member's need for PT, OT, or SLP services is expected to exceed the maximum allowable treatment days for that SOI.

Topic #2740

Extension of Therapy Services Required

PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) providers are required to request extension of therapy services (instead of SOI (spell of illness)) when any of the following are true:

- The onset of the member's condition has been acute, such as with a stroke.
- The member's condition does not meet the criteria for SOI approval.

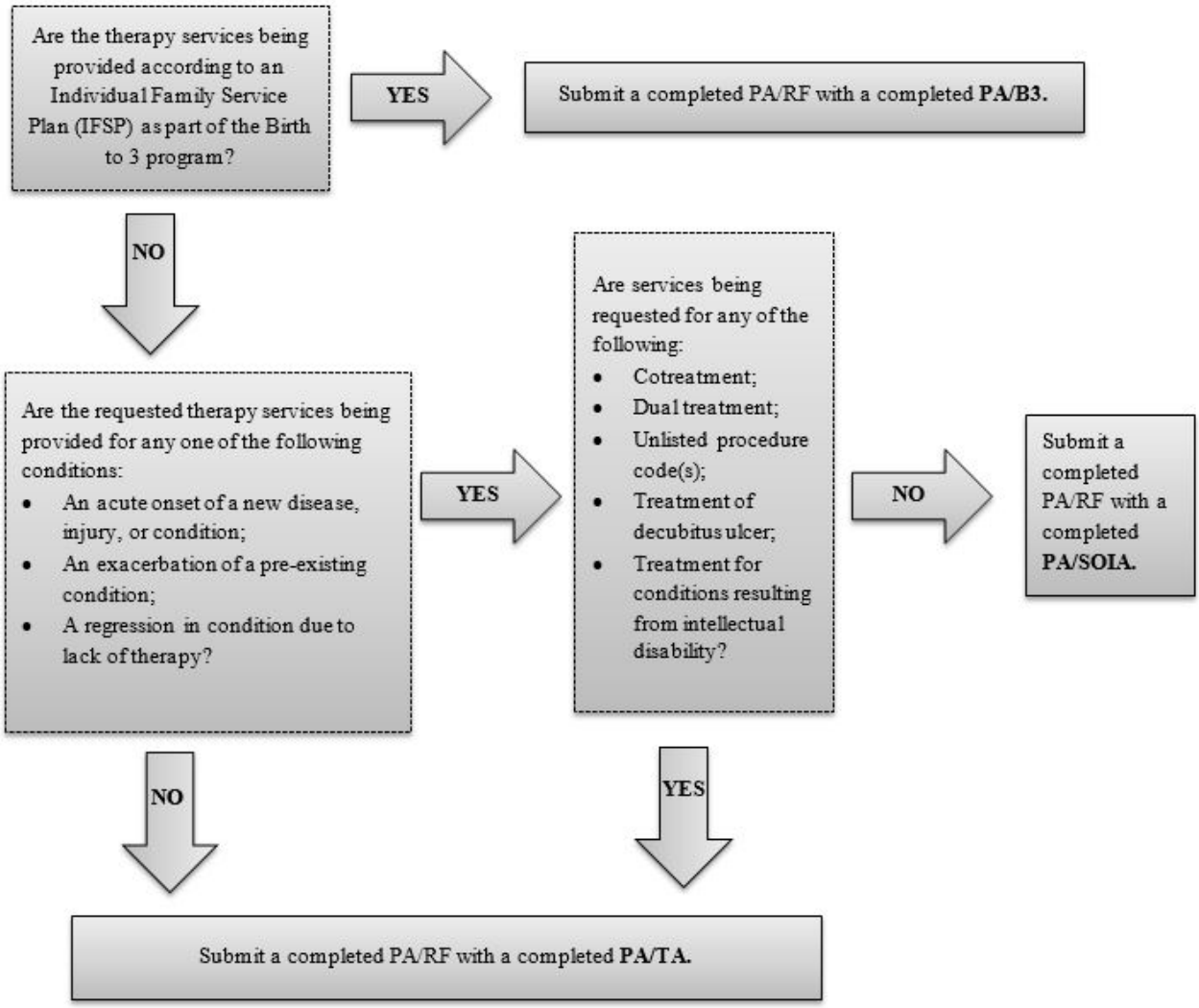
Certain conditions never qualify for an SOI, such as intellectual disability. These services always require PA (prior authorization).

Topic #2739

Prior Authorization Request Attachment Forms Flowchart

The following flowchart may be used to determine which attachment form should be sent with a PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) to request PA (prior authorization) for OT (occupational therapy), PT (physical therapy), and SLP (speech and language pathology) services following use of the initial 35 DOS (dates of service) of service in a member's lifetime that do not require PA. Providers are responsible for submitting and obtaining PA when required using the most appropriate attachment form. The three form attachments available for use when requesting PA for therapy services are:

- The PA/B3 (Prior Authorization/Birth to 3 Attachment, F-11011 (07/2012))
- The PA/SOIA (Prior Authorization/Spell of Illness Attachment, F-11039 (10/2015))
- The PA/TA (Prior Authorization/Therapy Attachment, F-11008 (04/2025))



Topic #2738

Overview

PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) providers may always choose to request extension of therapy services instead of SOI (spell of illness). For example, a provider may request extension of therapy services instead of SOI when treating an acute onset of a condition, such as a stroke. However, ForwardHealth will not approve a request for SOI when extension of therapy services is necessary.

Requesting Services for Birth to 3 Participants

Topic #2723

Requirements

ForwardHealth requires PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) providers to submit a PA (prior authorization) request only once per child, per therapy discipline, per billing provider for members who participate in the Birth to 3 Program. An approved PA is granted up to the member's third birthday.

Birth to 3 services must be provided by PT, OT, and SLP providers who are employed by, or under agreement with, a Birth to 3 agency to provide Birth to 3 services. In addition, the Birth to 3 services must be one or both of the following:

- Provided in conjunction with the Birth to 3 initial evaluation and assessment in accordance with Wis. Admin. Code ch. DHS 90, even if the evaluation and assessment determines the child is not eligible for Birth to 3 services.
- Identified in the member's IFSP (Individualized Family Service Plan) and performed at the same frequency, intensity, and duration listed in the IFSP. Wisconsin Medicaid will not reimburse the provider beyond the frequency and duration specified in the prescription or the physician-signed plan of care.

Providers may submit the PA/B3 (Prior Authorization/Birth to 3 Attachment, F-11011 (07/2012)) in either of the following situations:

- At any time once an evaluation or a PT, OT, or SLP service has been initiated through the Birth to 3 Program
- At any time cotreatment is being provided by two therapy providers through the Birth to 3 Program
- Two to four weeks before the child's initial 35 treatment days per discipline have been used

Topic #2722

Situations That Do Not Qualify for the Birth to 3 Prior Authorization Process

Providers may not use the PA (prior authorization) Birth to 3 process for any of the following:

- Children who are not being evaluated as part of an initial Birth to 3 assessment or who are not participating in the Birth to 3 Program (Some children are not eligible for the Birth to 3 Program. One example would be a child without developmental delays who needs therapy to recover from an accident or injury, such as a broken arm. Providers are required to indicate the reason the child is not a Birth to 3 member.)
- Services provided by ForwardHealth PT (physical therapy), OT (occupational therapy), or SLP (speech and language pathology) providers who are not employed by, or under agreement with, a Birth to 3 agency to provide Birth to 3 services
- Services not identified in the IFSP (Individualized Family Service Plan)
- Procedure codes not listed in the Birth to 3 list as appropriate for PT, OT, or SLP

For situations that do not meet the criteria for the PA Birth to 3 process, providers are required to submit the PA/TA (Prior Authorization/Therapy Attachment, F-11008 (04/2025)) or the PA/SOIA (Prior Authorization/Spell of Illness Attachment, F-11039 (10/2015)). Providers are not required to submit a PA/TA for cotreatment services. Providers should refer to the Requesting Services That Always Require Prior Authorization and the Requesting Spell of Illness chapters for information about submitting the PA/TA or PA/SOIA.

Providers are required to include the following components of the IFSP when submitting the PA/TA for Birth to 3 participants:

- The child's health history and current medical status, including results of hearing and vision screening
- A summary of the child's development in the following five areas:
  - Cognitive skills
  - Physical development (fine and gross motor skills)
  - Communication skills
  - Social or emotional development
  - Adaptive development (including self-help skills)
- Concerns, priorities, and resources as identified by the family and other team members
- Functional outcomes (including the follow-through plans for the child's family and any outcome evaluation criteria)
- Summary of services

In accordance with Wis. Admin. Code ch. DHS 90, the IFSP describes the outcomes, strategies, supports, and services appropriate to meet the child's and family's needs. The IFSP does not establish medical necessity.

After the IFSP has been submitted once, only the sections of the IFSP that change significantly need to be submitted to ForwardHealth. This typically includes the following:

- The annual update on developmental status
- Changes in desired outcomes that may be developed at either six-month or annual reviews

Prior Authorization Requests for Therapy Services Provided Outside the Birth to 3 Program

Per Wis. Admin. Code § DHS 90.07(3)(b), when submitting non-Birth to 3 PA requests for therapeutic services for children ages 0–3 years (for example, outpatient treatment PA requests for therapeutic services), providers must confirm that the child has been referred to the Birth to 3 Program. Confirmation of referral can be completed by, but is not limited to, caregiver discussion regarding the availability of the Birth to 3 Program, review of member medical records with confirmed referral in the record, or direct referral by the therapy provider to the Birth to 3 Program.

Providers may provide the IFSP or Child Enrollment Status Regarding Birth to 3 Program (F-00316 (03/2017)) form as a method of confirmation that the child has been referred to the Birth to 3 Program, but the IFSP and Child Enrollment Status Regarding Birth to 3 Program form are not required to be submitted for children ages 0–3 years.

Providers should ensure that the method of confirmation of the referral is maintained in the member's medical records and is readily available upon audit requests.

Advanced Imaging Services

Topic #10678

Prior Authorization for Advanced Imaging Services

Most advanced imaging services, including CT (computed tomography), MR (magnetic resonance), MRE (magnetic resonance elastography), and PET (positron emission tomography) imaging, require PA (prior authorization) when performed in either outpatient hospital settings or in non-hospital settings (for example, radiology clinics). eviCore healthcare, a private radiology benefits manager, is authorized to administer PA for advanced imaging services on behalf of ForwardHealth. Refer to the Prior Authorization section of the Radiology area of the Online Handbook for PA requirements and submission information for advanced imaging services.

Health systems, groups, and individual providers that order CT, MR, and MRE imaging services and have implemented decision support tools may request an exemption from PA requirements for these services. Upon approval, ForwardHealth will recognize the requesting provider's advanced imaging decision support tool (for example, ACR Select, Medicalis) as an alternative to current PA requirements for CT, MR, and MRE imaging services.

Requesting Services for Children Under 6

Topic #21280

Requesting Services for Children Under 6

Required Documentation

Providers are required to submit the following documents when requesting therapeutic services for members under 6 years of age:

- A completed PA/RF (Prior Authorization Request Form, F-11018 (05/2013))
- A PA/TA (Prior Authorization/Therapy Attachment, F-11008 (04/2025))
- A written report of the most recent assessment or evaluation of the member
- If submitting a PA (prior authorization) request for continuation of therapy, measurable data that reflects the member's response to treatment (This may be reported in a current POC (plan of care) with progress data or in an assessment with member results.)

Also, per Wis. Admin. Code § DHS 90.07(3)(b), when submitting non-Birth to 3 PA requests for therapeutic services for children ages 0–3 years (that is, outpatient treatment PA requests for therapeutic services), providers must confirm that the child has been referred to the Birth to 3 Program. Confirmation of referral can be completed by, but is not limited to, caregiver discussion regarding the availability of the Birth to 3 Program, review of member medical records with confirmed referral in the record, or direct referral by the therapy provider to the Birth to 3 Program.

Providers may provide the IFSP (Individualized Family Service Plan) or Child Enrollment Status Regarding Birth to 3 Program (F-00316 (03/2017)) form as a method of confirmation that the child has been referred to the Birth to 3 Program, but the IFSP and Child Enrollment Status Regarding Birth to 3 Program form are not required to be submitted for children ages 0–3 years.

Providers should ensure that the method of confirmation of the referral is maintained in the member's medical records and is readily available upon audit requests.

Frequency and Duration

Each PA request for members under 6 years of age may be approved with the simplified PA process for up to two therapy sessions per week. To request more than two sessions per week, providers must submit all required documentation consistent with current policy to allow a full medical necessity review and substantiate the requested frequency of sessions. PA requests for members under 6 years of age may be approved for up to 53 consecutive weeks.

ForwardHealth allows flexible use of approved, medically necessary PT, OT, and SLP sessions so a provider may meet the member's needs.

Requesting Services for Birth to 3 Participants

Refer to Requesting Services for Birth to 3 Participants for information about the Birth to 3 PA process.

Claims

4

Archive Date:07/01/2025

Claims:Submission

Topic #17797

1500 Health Insurance Claim Form Completion Instructions

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

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

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

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

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

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

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Topic #10677

Advanced Imaging Services

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

Submitting Claims for Situations Exempt From the Prior Authorization Requirement

In the following situations, PA is not required for advanced imaging services:

- The service is provided during a member's inpatient hospital stay.
- The service is provided when a member is in observation status at a hospital.
- The service is provided as part of an emergency room visit.
- The service is provided as an emergency service.

Service Provided During an Inpatient Stay

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

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

Service Provided for Observation Status

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

Providers using a paper institutional claim form should include modifier UA in Form Locator 44 (HCPCS (Healthcare Common Procedure Coding System)/Rate/HIPPS Code) with the procedure code for the advanced imaging service. To indicate a modifier on an institutional claim, enter the appropriate five-digit procedure code in Form Locator 44, followed by the two-digit modifier. Providers submitting claims electronically using the 837I (837 Health Care Claim: Institutional) should refer to the appropriate companion guide for instructions on including a modifier.

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

Service Provided as Part of Emergency Room Visit

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

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

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

Service Provided as Emergency Service

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

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

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

Topic #542

Attached Documentation

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

Topic #2769

Multiple Services During One Session

Multiple procedure codes may be prior authorized in anticipation of the required services. However, only the procedure codes that reflect the services actually provided on that DOS (date of service) may be indicated on the claim. Claims found to be in conflict with this program requirement will be recouped.

Topic #15737

Claims for Services Prescribed, Referred, or Ordered

Claims for services that are prescribed, referred, or ordered services must include the Type 1 NPI (National Provider Identifier) of the Medicaid-enrolled provider who prescribed, referred, or ordered the service. ForwardHealth will deny claims if they do not include a Medicaid-enrolled provider's NPI or if they are submitted with the NPI of a provider who is not enrolled with Wisconsin Medicaid. (However, providers should **not** include the NPI of a provider who prescribes, refers, or orders services on claims for services that are not prescribed, referred, or ordered, as those claims will also deny if the provider is not enrolled in Medicaid.)

Note: Claims submitted for ESRD (end-stage renal disease) services do not require **referring** provider information; however, **prescribing** and **ordering** provider information will still be required on claims.

Contacting Prescribing/Referring/Ordering Provider After a Claim Denial

If a claim is denied for prescribed, referred, or ordered services because the prescribing/referring/ordering provider was not Medicaid-enrolled, the rendering provider should contact the prescribing/referring/ordering provider and:

- Communicate that the prescribing/referring/ordering provider is must be enrolled in Wisconsin Medicaid.
- Inform the prescribing/referring/ordering provider of the limited enrollment available for prescribing/referring/ordering providers.
- Resubmit the claim once the prescribing/referring/ordering provider has enrolled in Wisconsin Medicaid.

Exception for Prescribed, Referred, or Ordered Services Prior to a Member's Medicaid Enrollment

Providers may submit claims for prescribed, referred, or ordered services by a non-Medicaid-enrolled provider if the member was not yet enrolled in Wisconsin Medicaid at the time the prescription, referral, or order was written (and the member has since enrolled in Wisconsin Medicaid). However, once the prescription, referral, or order expires, the prescribing/referring/ordering provider is required to enroll in Wisconsin Medicaid if they continue to prescribe, refer, or order services for the member.

The procedures for submitting claims for this exception depend on the type of claim submitted:

- Institutional, professional, and dental claims for this exception must be sent to the following address:

  ForwardHealth
  P.R.O. Exception Requests
  Ste 50
  313 Blettner Blvd
  Madison WI 53784

  A copy of the prescription, referral, or order must be included with the claim.

- Pharmacy and compound claims for this exception do **not** require any special handling. These claims include a prescription date, so they can be processed to bypass the prescriber Medicaid enrollment requirement in situations where the provider prescribed services before the member was enrolled in Wisconsin Medicaid.

Topic #6957

Copy Claims on the ForwardHealth Portal

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

Topic #5017

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

Providers can view EOB (Explanation of Benefits) codes and descriptions for any claim submitted to ForwardHealth on the

ForwardHealth Portal. The EOBs help providers determine why a claim did not process successfully, so providers may correct the error online and resubmit the claim. The EOB appears on the bottom of the screen and references the applicable claim header or detail.

Topic #4997

Direct Data Entry of Professional and Institutional Claims on the Portal

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

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

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

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

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

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

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

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

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

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

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

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

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

Topic #344

Electronic Claim Submission

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

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

Topic #2771

Electronic Claim Submission for Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services

Electronic claims for PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services must be submitted using the 837P (837 Health Care Claim: Professional) transaction. Electronic claims for PT, OT, and SLP services submitted using any transaction other than the 837P will be denied.

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

Provider Electronic Solutions Software

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

Topic #16937

Electronic Claims and Claim Adjustments With Other Commercial Health Insurance Information

Effective for claims and claim adjustments submitted electronically via the Portal or PES software on and after June 16, 2014, other insurance information must be submitted at the detail level on professional, institutional, and dental claims and adjustments if

it was processed at the detail level by the primary insurance. Except for a few instances, Wisconsin Medicaid or BadgerCare Plus is the payer of last resort for any covered services; therefore, providers are required to make a reasonable effort to exhaust all existing other health insurance sources before submitting claims to ForwardHealth or to a state-contracted MCO (managed care organization).

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

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

Adjustments to Claims Submitted Prior to June 16, 2014

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

Topic #2770

Evaluations

Claims for evaluations and re-evaluations may be submitted only upon completion regardless of the number of days needed to complete the evaluation. Evaluations and re-evaluations are not reimbursable for the same DOS ().

When submitting claims, providers are required to indicate a quantity of "1.0" for each evaluation instead of indicating a unit of "1.0" for every 15 minutes.

A unit of "1.0" submitted refers to the completion of an evaluation or re-evaluation regardless of time required to complete evaluation.

Topic #365

Extraordinary Claims

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

Topic #4837

HIPAA-Compliant Data Requirements

Procedure Codes

All fields submitted on paper and electronic claims are edited to ensure HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance before being processed. Compliant code sets include CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) procedure codes entered into all fields, including those fields that are Not Required or Optional.

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

Provider Numbers

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

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

Topic #562

Managed Care Organizations

Claims for services that are covered in a member's state-contracted MCO (managed care organization) should be submitted to that MCO.

Topic #10837

Note Field for Most Claims Submitted Electronically

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

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

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

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

- Professional
- Institutional
- Dental

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

Claims Submitted via 837 Health Care Claim Transactions

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

Topic #561

Paper Claim Form Preparation and Data Alignment Requirements

Optical Character Recognition

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

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

Speed and Accuracy of Claims Processing

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

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

Handwritten Claims

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

Use Original Claim Forms

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

Use Laser or Ink Jet Printers

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

Alignment

Alignment within each field on the claim form needs to be accurate. If text within a field is aligned incorrectly, the OCR software

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

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

The following sample claim forms demonstrate correct and incorrect alignment:

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

Clarity

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

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

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

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

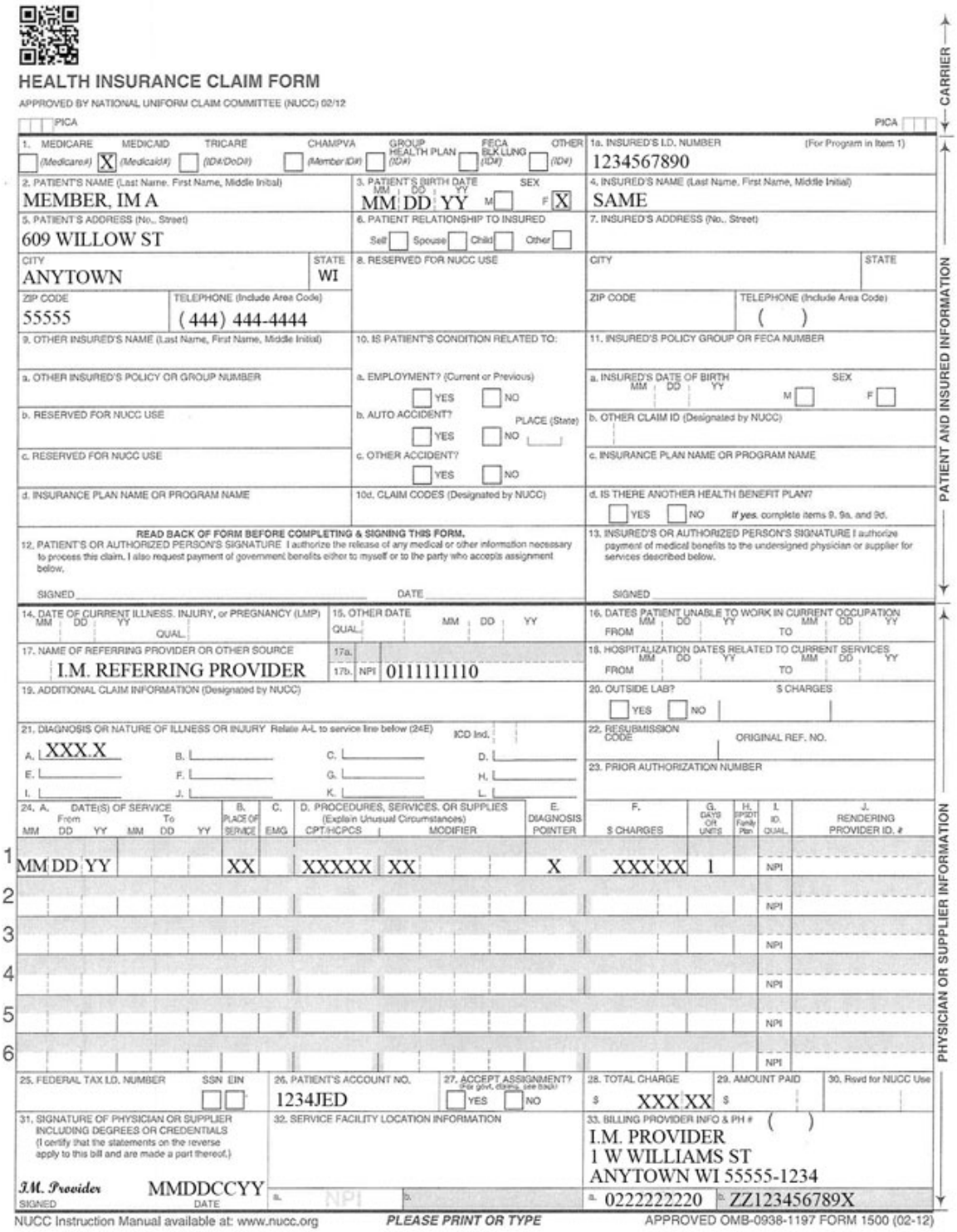
Staples, Correction Liquid, and Correction Tape

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

Additional Diagnosis Codes

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

Sample of a Correctly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

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

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

CITY: ANYTOWN | STATE: WI

8. RESERVED FOR NUCC USE

CITY: | STATE:

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

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

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

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: DATE:

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

SIGNED:

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

15. OTHER DATE QUAL. MM DD YY:

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

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

17a.

17b. NPI: 0111111110

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. XXX.X B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

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

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

26. PATIENT'S ACCOUNT NO.: 1234JED

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

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

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

I.M. Provider MMDDCCYY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH #: ( )

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

a. 0222222220 b. ZZ123456789X

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

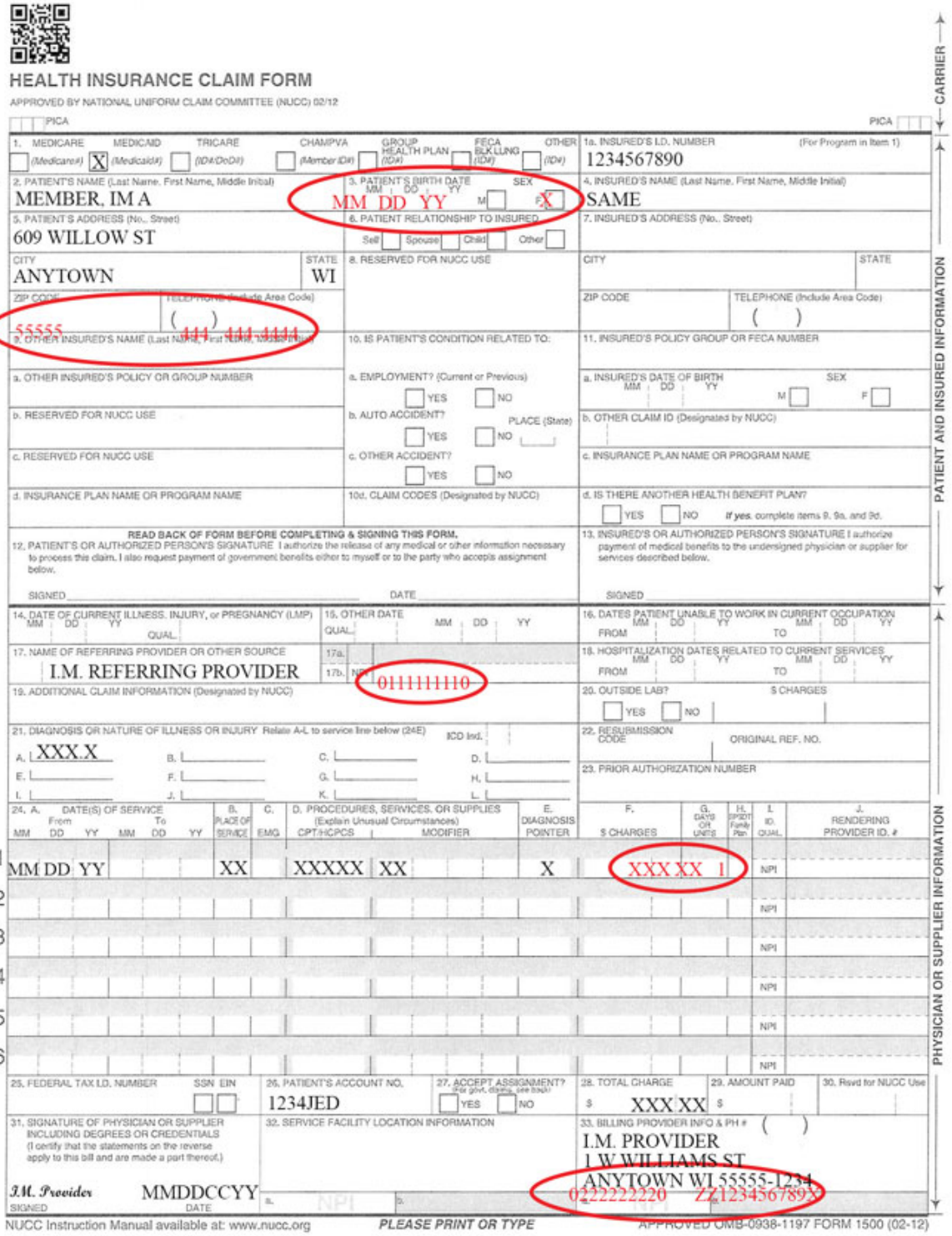
APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample of an Incorrectly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

CITY: ANYTOWN | STATE: WI

8. RESERVED FOR NUCC USE

CITY | STATE

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

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

15. OTHER DATE QUAL. MM DD YY

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

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

17a.

17b. NPI 0111111110

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. XXX.X B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

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

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

I.M. Provider MMDDCCYY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

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

CARRIER

PATIENT AND INSURED INFORMATION

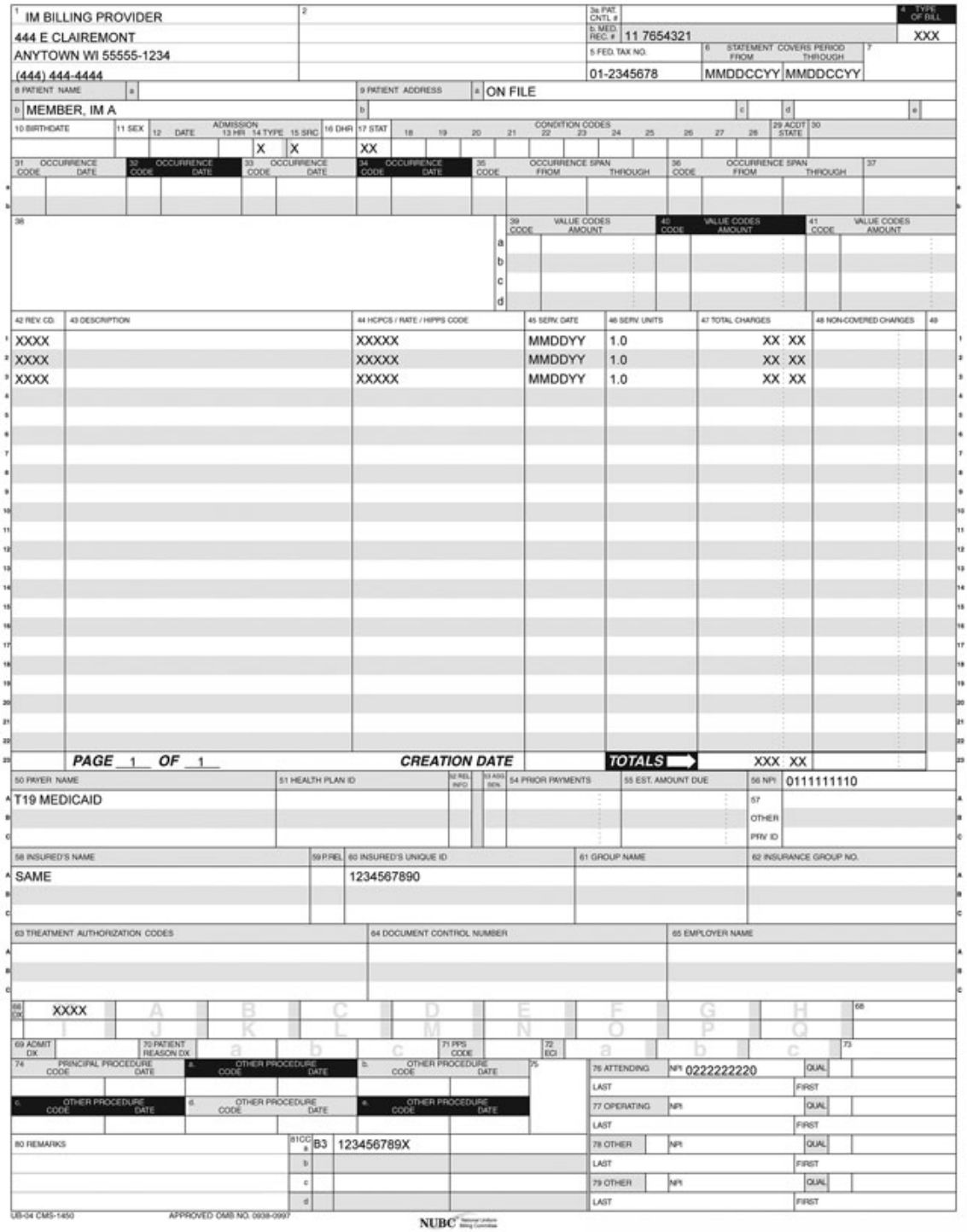
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Sample of a Correctly Aligned UB-04 Claim Form



1 IM BILLING PROVIDER 444 E CLAIREMONT ANYTOWN WI 55555-1234 (444) 444-4444	4 TYPE OF BILL: XXX 3b MED REC #: 11 7654321 5 FED TAX NO.: 01-2345678 6 STATEMENT COVERS PERIOD FROM: MMDDCCYY THROUGH: MMDDCCYY
8 PATIENT NAME: b MEMBER, IM A	9 PATIENT ADDRESS: a ON FILE
10 BIRTHDATE	11 SEX:	12 ADMISSION DATE:	13 HR:	14 TYPE: X	15 SRC: X	16 DHR:	17 STAT: XX
29 ACDT STATE:	30

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

50 PAYER NAME	51 HEALTH PLAN ID	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
A T19 MEDICAID				0111111110	

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

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX	68
XXXX	

69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75

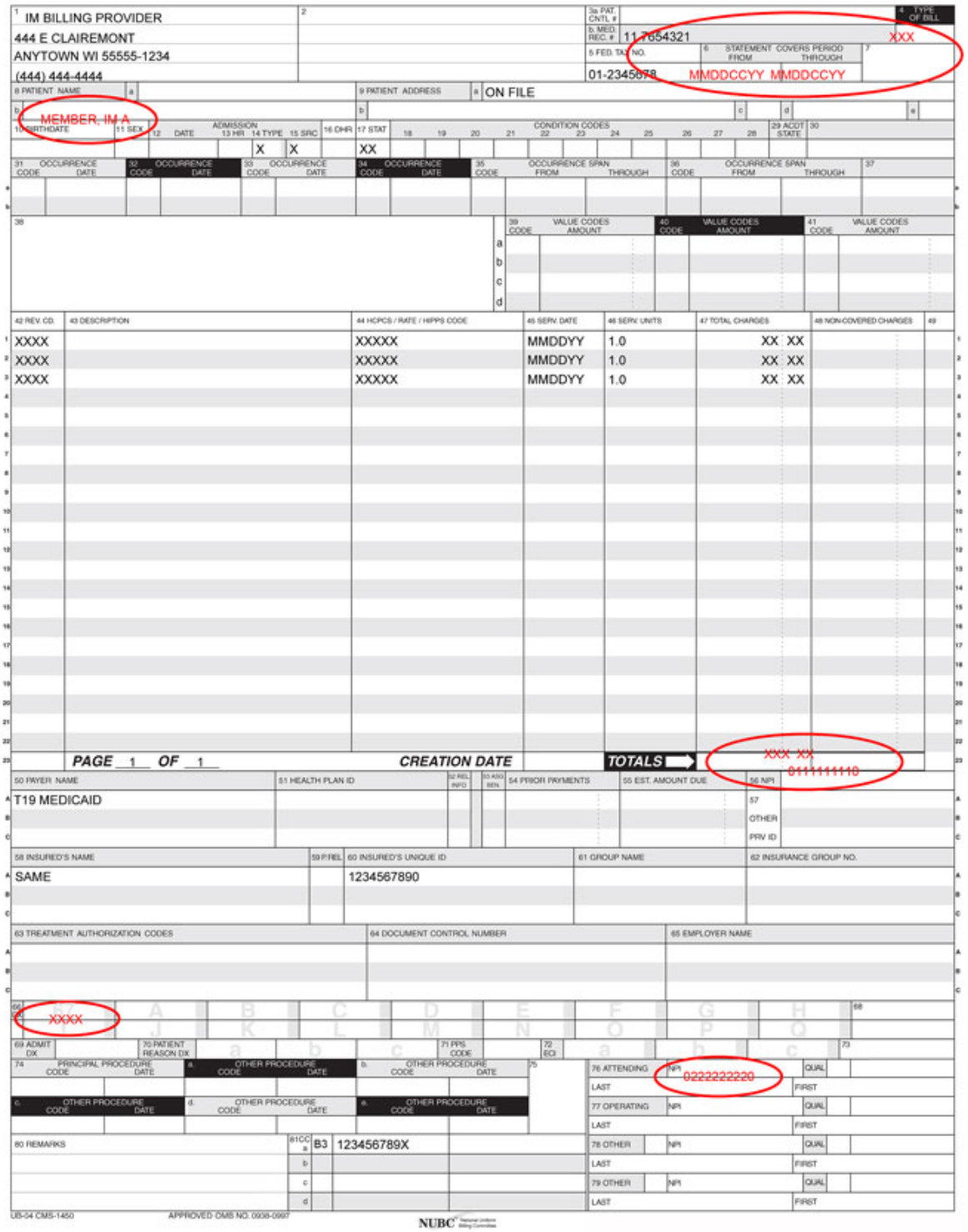
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE

80 REMARKS	81CC		
	a	B3	123456789X
	b		
	c		
	d		

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

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

Sample of an Incorrectly Aligned UB-04 Claim Form



Topic #2768

Paper Claim Submission

Paper claims for PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services must be submitted using the 1500 Health Insurance Claim Form ((02/12)). Paper claims for PT, OT, and SLP services submitted on any other claim form will be denied.

Providers should use the appropriate claim form instructions for PT, OT, and SLP services when submitting these claims.

Obtaining the Forms

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

Topic #22797

Payment Integrity Review Supporting Documentation

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

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

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

Topic #10177

Prior Authorization Numbers on Claims

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

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

Topic #2765

Provider Numbers for Groups, Clinics, and Nursing Homes

When the rendering provider is employed by, or under contract to, a therapy group, therapy clinic, speech and hearing clinic, or nursing home, the billing provider number of the group, clinic, or nursing home must be indicated on the claim. A performing provider number must be indicated.

Topic #2763

Provider Numbers for Hospitals

When the rendering provider is employed by, or under contract to, a hospital and offering **outpatient** hospital PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services, the billing provider number of the hospital must be indicated on the claim. A rendering provider number should not be indicated.

When the rendering provider is employed by, or under contract to, a hospital and offering **off-site** hospital PT, OT, or SLP services, the billing provider number of the therapist must be indicated on the claim. A rendering provider number should not be indicated.

When the rendering provider is supervised by a therapist who is employed by, or under contract to, a hospital and offering off-site hospital PT, OT, or SLP services, the billing provider number of the supervising therapist must be indicated on the claim. If the rendering provider is a PTA (physical therapist assistant), COTA (certified occupational therapy assistant), or SLP provider assistant, the rendering provider number of the assistant must be indicated.

Topic #2764

Provider Numbers for Individual Providers

When the rendering provider is an individual therapist, the billing provider number of the therapist must be indicated on the claim. A rendering provider number should not be indicated.

When the rendering provider is supervised by an individual therapist, the billing provider number of the supervising therapist must be indicated on the claim. If the rendering provider is a PTA (physical therapist assistant), COTA (certified occupational therapy assistant), or SLP (speech and language pathology) provider assistant, the rendering provider of the assistant must be indicated.

Topic #2762

Provider Numbers for Rehabilitation Agencies

When the rendering provider is employed by or under contract to a rehabilitation agency, the billing provider number of the rehabilitation agency must be indicated on the claim. A rendering provider number should not be indicated.

Topic #2761

Referring Provider

Claims for PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services require the referring physician's name and NPI (National Provider Identifier).

Topic #10637

Reimbursement Reduction for Most Paper Claims

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

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

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

The reimbursement reduction applies to the following paper claims:

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

Exceptions to Paper Claim Reimbursement Reduction

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

- In-state emergency providers
- Out-of-state providers
- Medicare crossover claims
- Any claims that ForwardHealth requires additional supporting information to be submitted on paper, such as:
  - Hysterectomy claims must be submitted along with an Acknowledgment of Receipt of Hysterectomy Information (F-01160 (06/2013)) form.
  - Sterilization claims must be submitted along with a paper Consent for Sterilization (F-01164 (10/2008)) form.
  - Claims submitted to Timely Filing appeals must be submitted on paper with a Timely Filing Appeals Request (F-13047 (08/2015)) form.
  - In certain circumstances, drug claims must be submitted on paper with a Pharmacy Special Handling Request (F-13074 (04/2014)) form.
  - Claims submitted with four or more NDCs (National Drug Codes) for compound and noncompound drugs with specific and non-specific HCPCS (Healthcare Common Procedure Coding System) procedure codes.

Topic #2760

Services Provided Beyond Daily Limits

When a PT (physical therapy), OT (occupational therapy), or SLP (speech and language pathology) service is indicated by a procedure code that specifies the unit of time provided beyond 90 minutes per day, the provider should submit a claim for the actual duration of the service provided. After the claim is reimbursed, an Adjustment/Reconsideration Request (F-13046 (08/2015)) form must be submitted with documentation verifying that the duration of the service was medically necessary.

Topic #4817

Submitting Paper Attachments With Electronic Claims

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

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

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

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

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

This does not apply to compound and noncompound claims.

Topic #11677

Uploading Claim Attachments Via the Portal

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

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

Claim Types

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

- Professional
- Institutional
- Dental

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

Document Formats

Providers are able to upload documents in the following formats:

- JPEG (.jpg or .jpeg)
- PDF (.pdf)
- Rich Text Format (.rtf)
- Text File (.txt)

JPEG files must be stored with a .jpg or .jpeg extension; text files must be stored with a .txt extension; rich text format files must be stored with a .rtf extension; and PDF files must be stored with a .pdf extension.

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

Uploading Claim Attachments

Claims Submitted by Direct Data Entry

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

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

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

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

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

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

Responsibilities

Topic #516

Accuracy of Claims

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

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

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

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

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

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

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

Topic #366

Copayment Amounts

Copayment amounts collected from members should not be deducted from the charges submitted on claims. Providers should indicate their usual and customary charges for all services provided.

In addition, copayment amounts should not be included when indicating the amount paid by other health insurance sources.

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

Topic #22798

Payment Integrity Review Program

The PIR (Payment Integrity Review) program:

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

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

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

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

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

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

Payment Integrity Review Program Overview

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

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

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

Types of Payment Integrity Review

There are three types of review in the PIR program:

- Claims Review
- Pre-Payment Review
- Intermediate Sanctions

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

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

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

Claims Review

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

Pre-Payment Review

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

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

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

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

Intermediate Sanction Review

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

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

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

Topic #547

Submission Deadline

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

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

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

Claims

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

Crossover Claims

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

Exceptions to the Submission Deadline

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

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

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

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

Topic #517

Usual and Customary Charges

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

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

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

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

Responses

Topic #540

An Overview of the Remittance Advice

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

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

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

Topic #5091

National Provider Identifier on the Remittance Advice

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

Topic #4818

Calculating Totals on the Remittance Advice for Adjusted and Paid Claims

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

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

Topic #534

Claim Number

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

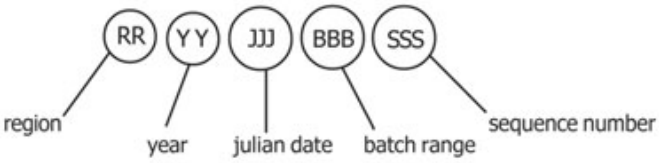
control number)). However, denied real-time compound and noncompound claims are not assigned an ICN, but receive an authorization number. Authorization numbers are not reported to the RA (Remittance Advice) or 835 (835 Health Care Claim Payment/Advice).

Interpreting Claim Numbers

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

Interpreting Claim Numbers

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



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

Topic #535

Claim Status

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

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

Topic #22277

Claims Denial Adjustment/Review Request

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

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

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

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

Topic #644

ClaimsXten Review

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

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

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

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

Areas Monitored by ClaimsXten

ClaimsXten uses rules to monitor certain claim situations.

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

ForwardHealth uses ClaimsXten software to monitor the following situations:

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

ClaimsXten will not review claims that have been denied for general billing errors, such as an invalid member identification number or an invalid or missing provider number. Providers will need to correct the general billing error and resubmit the claim, at which point ClaimsXten will review the claim.

Unbundled and Rebundled Procedures

Unbundling occurs when two or more procedure codes are used to describe a procedure that may be better described by a single, more comprehensive procedure code. ClaimsXten considers the single, most appropriate procedure code for reimbursement when unbundling is detected.

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

ClaimsXten will also total billed amounts for individual procedures. For example, if the provider bills three procedures at $20, $30, and $25, ClaimsXten rebundles them into a single procedure code, adds the three amounts, and calculates the billed amount for a new rebundled code at $75. Then, ForwardHealth reimburses the provider either the lesser of the billed amounts or the maximum allowable fee for that rebundled procedure code.

Incidental/Integral Procedures

Incidental procedures are those procedures performed at the same time as a more complex primary procedure. These require few additional provider resources and are generally not considered necessary to the performance of the primary procedure. For example, the removal of an asymptomatic appendix is considered an incidental procedure when done during hysterectomy surgery.

Integral procedures are those procedures performed as part of a more complex primary procedure. For example, when a member undergoes a transurethral incision of the prostate, the scope procedure is considered integral to the performance of the prostate procedure and would be denied as a separately billed item.

When a procedure is either incidental or integral to a major procedure, ClaimsXten considers only the primary procedure for reimbursement.

Mutually Exclusive Procedures

Mutually exclusive procedures are procedures that would not be performed on a single member on the same day or that use different codes to describe the same type of procedure.

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

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

Medical Visit Billing Errors

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

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

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

Preoperative and Postoperative Billing Errors

Preoperative and postoperative billing errors occur when E&M services are billed with surgical procedures during their preoperative and postoperative periods. ClaimsXten bases the preoperative and postoperative periods on designations in the CMS National Physician Fee Schedule.

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

Assistant Surgeon Billing Errors

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

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

For example, if a provider bills a procedure code for a surgery with a modifier representing an assistant surgeon, and ClaimsXten determines that the procedure does not require an assistant surgeon, the procedure-modifier combination will be denied.

Topic #4746

Cutback Fields on the Remittance Advice for Adjusted and Paid Claims

Cutback fields indicate amounts that reduce the allowed amount of the claim. Examples of cutbacks include other insurance, member copays, spenddown amounts, deductibles, or patient liability amounts. Amounts indicated in a cutback field are subtracted from the total allowed reimbursement.

Providers should note that cutback amounts indicated in the header of an adjusted or paid claim section apply only to the header. Not all cutback fields that apply to a detail line (such as copays or spenddowns) will be indicated on the RA (Remittance Advice); the detail line EOB (Explanation of Benefits) codes inform providers that an amount was deducted from the total reimbursement but may not indicate the exact amount.

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

Topic #537

Electronic Remittance Information

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

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

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

Text File

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

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

Comma-Separated Values Downloadable File

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

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

The CSV files are generated per financial payer and listed by RA number and RA date. A separate CSV file is listed for the last

10 RAs. Providers can select specific sections of the RA by date to download, making the information easy to read and organize.

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

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

835

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

Provider Electronic Solutions Software

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

Topic #4822

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

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

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

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

TEXT File

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

CSV File

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

Topic #13437

ForwardHealth-Initiated Claim Adjustments

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

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

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

Topic #4820

Identifying the Claims Reported on the Remittance Advice

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

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

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

Topic #11537

National Correct Coding Initiative

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

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

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

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

Medically Unlikely Detail Edits

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

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

Procedure-to-Procedure Detail Edits

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

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

Quarterly Code List Updates

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

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

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

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

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

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

processing.

Topic #539

Obtaining the Remittance Advice

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

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

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

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

Topic #4745

Overview of Claims Processing Information on the Remittance Advice

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

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

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

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

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

- Adjusted claims
- Denied claims
- Paid claims

Claim Types	Provider Types
Dental claims	Dentists, dental hygienists, HealthCheck agencies that provide dental services
Inpatient claims	Inpatient hospital providers and institutes for mental disease providers
Long term care claims	Nursing homes
Medicare crossover institutional claims	Most providers who submit claims on the UB-04
Medicare crossover professional claims	Most providers who submit claims on the 1500 Health Insurance Claim Form ((02/12))
Noncompound and compound drug claims	Pharmacies and dispensing physicians
Outpatient claims	Outpatient hospital providers and hospice providers
Professional claims	Ambulance providers, ambulatory surgery centers, anesthesiologist assistants, audiologists, case management providers, certified registered nurse anesthetists, chiropractors, community care organizations, community support programs, crisis intervention providers, day treatment providers, family planning clinics, federally qualified health centers, HealthCheck providers, HealthCheck "Other Services" providers, hearing instrument specialists, home health agencies, independent labs, individual medical supply providers, medical equipment vendors, mental health/substance abuse clinics, nurses in independent practice, nurse practitioners, occupational therapists, opticians, optometrists, personal care agencies, pharmacists, physical therapists, physician assistants, physician clinics, physicians, podiatrists, portable X-ray providers, prenatal care coordination providers, psychologists, rehabilitation agencies, respiratory therapists, rural health clinics, school-based services providers, specialized medical vehicle providers, speech and hearing clinics, speech-language pathologists, therapy groups

Topic #4821

Prior Authorization Number on the Remittance Advice

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

Topic #4418

Reading Non-Claims Processing Sections of the Remittance Advice

Address Page

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

Banner Messages

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

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

Explanation of Benefits Code Descriptions

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

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

Financial Transactions Page

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

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

Refunds are payments made to providers for overpayments.

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

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

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

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

Type of Character and Description	Applicable Characters and Description
Transaction—The first character indicates the type of financial transaction that created the accounts receivable.	V—Capitation adjustment 1—OBRA Level 1 screening void request 2—OBRA Nurse Aide Training/Testing void request

Identifier—10 additional numbers are assigned to complete the Adjustment ICN.	The identifier is used internally by ForwardHealth.

Service Code Descriptions

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

Summary

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

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

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

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

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

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

Topic #368

Reading the Claim Adjustments Section of the Remittance Advice

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

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

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

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

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

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

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

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

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

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

Topic #4824

Reading the Claims Denied Section of the Remittance Advice

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

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

Sample Professional Services Claims Denied Section of the Remittance Advice

Remittance Advice — Professional Service Claims Denied Sample

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

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

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

MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS  XXXXXXXXXXXX  XXXXXXXXXXXX  MMDDYY MMDDYY  999,999,999.99   9,999,999.99    999,999.99

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

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


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

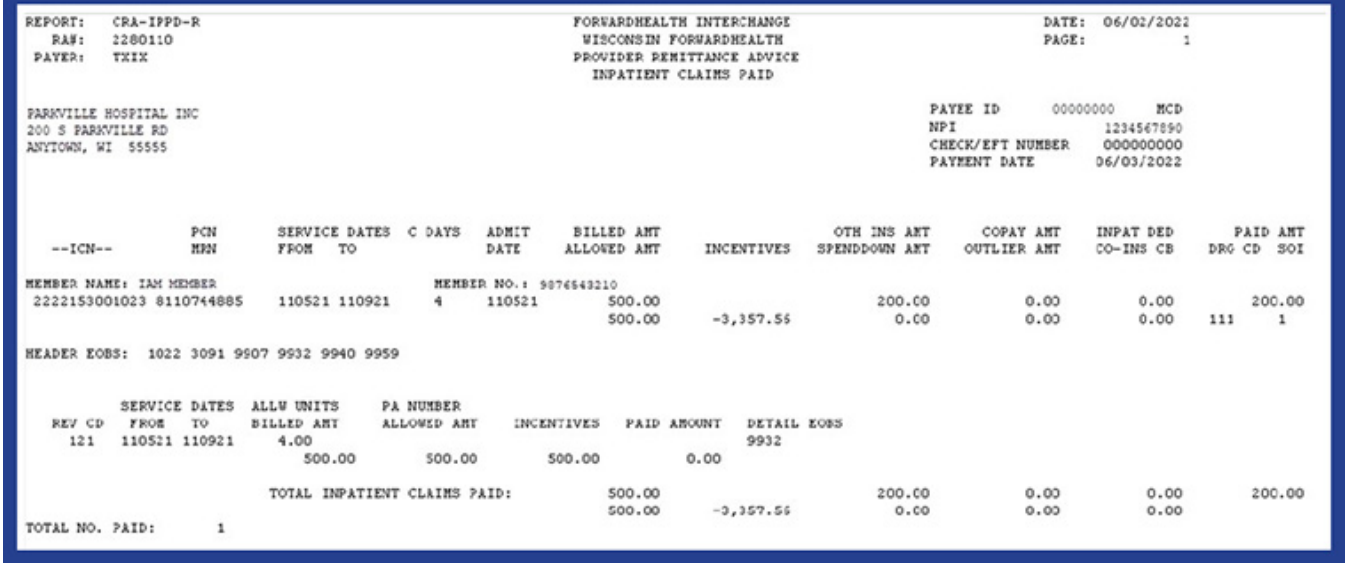
Topic #4825

Reading the Claims Paid Section of the Remittance Advice

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

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

Sample Inpatient Claims Paid Section of the Remittance Advice



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

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


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

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

HEADER EOBS:  1022 3091 9907 9932 9940 9959


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

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

Topic #4828

Remittance Advice Financial Cycles

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

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

Topic #4827

Remittance Advice Generated by Payer and by Provider Enrollment

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

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

A separate Portal account is required for each financial payer.

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

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

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

Topic #6237

Reporting a Lost Check

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

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

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

ForwardHealth
Financial Services
313 Blettner Blvd
Madison WI 53784

Topic #5018

Searching for and Viewing All Claims on the Portal

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

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

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

Topic #4829

Sections of the Remittance Advice

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

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

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

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

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

Remittance Advice Header Information

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

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

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

The following information is in the middle of the header:

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

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

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

Topic #544

Verifying Accuracy of Claims Processing

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

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

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

Adjustment Requests

Topic #814

Allowed Claim

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

Topic #815

Denied Claim

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

Topic #512

Electronic

837 Transaction

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

Provider Electronic Solutions Software

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

Portal Claim Adjustments

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

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

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

Topic #513

Follow-Up

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

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

Topic #515

Paper

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

Topic #816

Processing

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

Topic #514

Purpose

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

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

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

Topic #4857

Submitting Paper Attachments with Electronic Claim Adjustments

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

Good Faith Claims

Topic #518

Definition of Good Faith Claims

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

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

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

Timely Filing Appeals Requests

Topic #549

Requirements

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

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

Topic #551

Resubmission

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

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

Topic #744

Submission

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

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

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

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

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

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

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

	¡ Temporary Identification Card for Express Enrollment in BadgerCare Plus ¡ Temporary Identification Card for Express Enrollment in Family Planning Only Services ¡ The response received through Wisconsin's EVS (Enrollment Verification System) from a commercial eligibility vendor ¡ The transaction log number received through WiCall ¡ The enrollment tracking number received through the ForwardHealth Portal	
ForwardHealth Reconsideration or Recoupment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when ForwardHealth reconsiders a previously processed claim. ForwardHealth will initiate an adjustment on a previously paid claim.	If a subsequent provider submission is required, the request must be submitted within 90 days from the date of the RA (Remittance Advice) message. Include the following documentation as part of the request: ı A copy of the RA message that shows the ForwardHealth-initiated adjustment ı A copy of the Explanation of Medical Benefits form, if applicable	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Retroactive Enrollment for Persons on General Relief		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when the income maintenance or tribal agency requests a return of a GR (general relief) payment from the provider because a member has become retroactively enrolled for Wisconsin Medicaid or BadgerCare Plus.	To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the member's enrollment information. Include the following documentation as part of the request: ı A copy of the Explanation of Medical Benefits form, if applicable **And** ı GR retroactive enrollment indicated on the claim **Or** ı A copy of the letter received from the income maintenance or tribal agency	ForwardHealth GR Retro Eligibility Ste 50 313 Blettner Blvd Madison WI 53784
Medicare Denial Occurs After the Submission Deadline		

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

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

Retroactive Member Enrollment into Medicaid		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a claim cannot be submitted within the submission deadline due to a delay in the	To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the member's enrollment information. In addition, retroactive enrollment	ForwardHealth Timely Filing Ste 50

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

Overpayments

Topic #528

Adjustment Request vs. Cash Refund

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

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

Topic #532

Adjustment Requests

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

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

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

Electronic Adjustment Requests

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

Paper Adjustment Requests

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

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

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

Topic #533

Cash Refunds

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

ForwardHealth
Financial Services Cash Unit
313 Blettner Blvd
Madison WI 53784

Topic #531

ForwardHealth-Initiated Adjustments

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

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

Topic #530

Requirements

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

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

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

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

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

Topic #8417

Voiding Claims

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

Reimbursement

5

Archive Date:07/01/2025

Reimbursement:Payer of Last Resort

Topic #242

Instances When Medicaid is Not Payer of Last Resort

Wisconsin Medicaid or BadgerCare Plus are **not** the payer of last resort for members who receive coverage from certain governmental programs, such as:

- Birth to 3
- Crime Victim Compensation Fund
- GA (General Assistance)
- HCBS (Home and Community-Based Services) waiver programs:
  - CLTS (Children's Long-Term Support Program)
  - Family Care
  - Family Care Partnership
  - IRIS (Include, Respect, I Self-Direct)
- IDEA (Individuals with Disabilities Education Act)
- Indian Health Service
- Maternal and Child Health Services
- WCDP (Wisconsin Chronic Disease Program):
  - Adult Cystic Fibrosis
  - Chronic Renal Disease
  - Hemophilia Home Care

Providers should ask members if they have coverage from these other governmental programs.

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

Topic #251

Other Health Insurance Sources

BadgerCare Plus reimburses only that portion of the allowed cost remaining after a member's other health insurance sources have been exhausted. Other health insurance sources include the following:

- Commercial fee-for-service plans
- Commercial managed care plans
- Medicare supplements (for example, Medigap)
- Medicare
- Medicare Advantage and Medicare Cost plans
- TriCare
- CHAMPVA (Civilian Health and Medical Plan of the Veterans Administration)
- Other governmental benefits

Topic #253

Payer of Last Resort

Except for a few instances, Wisconsin Medicaid or BadgerCare Plus is the payer of last resort for any covered services. Therefore, the provider is required to make a reasonable effort to exhaust all other existing health insurance sources before submitting claims to ForwardHealth or to a state-contracted MCO (managed care organization).

Topic #255

Primary and Secondary Payers

The terms primary payer and secondary payer indicate the relative order in which insurance sources are responsible for paying claims.

In general, commercial health insurance is primary to Medicare, and Medicare is primary to Wisconsin Medicaid and BadgerCare Plus. Therefore, Wisconsin Medicaid and BadgerCare Plus are secondary to Medicare, and Medicare is secondary to commercial health insurance.

Amounts

Topic #258

Acceptance of Payment

The amounts allowed as payment for covered services must be accepted as payment in full. Therefore, total payment for the service (for example, any amount paid by other health insurance sources, any BadgerCare Plus or Medicaid copay or spenddown amounts paid by the member, and any amount paid by BadgerCare Plus, Medicaid, or HDAP (Wisconsin HIV Drug Assistance Program)) may not exceed the allowed amount. As a result, providers may not collect payment from a member or authorized person acting on behalf of the member, for the difference between their usual and customary charge and the allowed amount for a service (for example, balance billing).

Other health insurance payments may exceed the allowed amount if no additional payment is received from the member or BadgerCare Plus, Medicaid, or HDAP.

Topic #694

Billing Service and Clearinghouse Contracts

According to Wis. Admin. Code § DHS 106.03(5)(c)2, contracts with outside billing services or clearinghouses may not be based on commission in which compensation for the service is dependent on reimbursement from BadgerCare Plus. This means compensation must be unrelated, directly or indirectly, to the amount of reimbursement or the number of claims and is not dependent upon the actual collection of payment.

Topic #8117

Electronic Funds Transfer

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

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

Provider Exceptions

EFT payments are not available to the following providers:

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

Enrolling in Electronic Funds Transfer

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

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

The following guidelines apply to EFT enrollment:

- Only a Portal Administrator or a clerk who has been assigned the EFT role on the Portal may complete the EFT enrollment information.
- Organizations can revert back to receiving paper checks by disenrolling in EFT.
- Organizations may change their EFT information at any time.
- Organizations will continue to receive their RA (Remittance Advice) as they do currently.

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

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

Recoupment and Reversals

Enrollment in EFT does not change the current process of recouping funds. Overpayments and recoupment of funds will continue to be conducted through the reduction of payments.

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

Problem Resolution

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

Topic #897

Fee Schedules

Maximum allowable fee information is available on the Max Fee Schedules page of the ForwardHealth Portal in the following forms:

- An interactive maximum allowable fee schedule
- Downloadable fee schedules by service area only in TXT (text) or CSV (comma separated value) files

Policy information is not displayed in the fee schedules. Providers should refer to their specific service area in the Online Handbook for more information about coverage policy related to a specific procedure code.

Certain fee schedules are interactive. On the interactive fee schedule, providers have more search options for looking up some coverage information, as well as the maximum allowable fees, as appropriate, for reimbursable HCPCS (Healthcare Common Procedure Coding System), CPT (Current Procedural Terminology), or CDT (Current Dental Terminology) procedure codes for most services.

Providers have the ability to independently search by:

- A single HCPCS, CPT, or CDT procedure code
- Multiple HCPCS, CPT, or CDT procedure codes
- A pre-populated code range
- A service area (Service areas listed in the interactive fee schedule more closely align with the provider service areas listed in the Online Handbook, including the WCDP (Wisconsin Chronic Disease Program) programs and WWWP (Wisconsin Well Woman Program).)

The downloadable fee schedules, which are updated monthly, provide basic maximum allowable fee information by provider service area.

Through the interactive fee schedule, providers can export their search results for a single code, multiple codes, a code range, or by service area. The export function of the interactive fee schedule will return a .zip file that includes seven CSV files containing the results.

Note: The interactive fee schedule will export all associated information related to the provider's search criteria except the procedure code descriptions.

Providers may call Provider Services in the following cases:

- The ForwardHealth Portal is not available.
- There is uncertainty as to which fee schedule should be used.
- The appropriate fee schedule cannot be found on the Portal.
- To determine coverage or maximum allowable fee of procedure codes not appearing on a fee schedule.

Topic #260

Maximum Allowable Fees

Maximum allowable fees are established for most covered services. Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

Providers are reimbursed at the lesser of their billed amount and the maximum allowable fee for the procedure.

Topic #2711

Maximum allowable fees for services provided through a rehabilitation agency vary among agencies. Agencies may obtain their agency-specific fee schedule by contacting Provider Services.

Hospitals may obtain maximum allowable fees for outpatient hospital PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services by referring to outpatient hospital publications.

Topic #2710

Natural Environment Enhanced Reimbursement

PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) providers receive an enhanced reimbursement from Wisconsin Medicaid or BadgerCare Plus when certain PT, OT, and SLP services are provided in the natural environment of a member who participates in the Birth to 3 Program. The enhanced reimbursement applies on a per child, per DOS (date of service), per therapy discipline basis. Providers are required to indicate the TL modifier (Early intervention/individualized family service plan [IFSP]) when submitting claims for the enhanced reimbursement.

ForwardHealth includes the enhanced reimbursement for natural environment in the claim reimbursement for the therapy.

Topic #2709

Reimbursement Methods

PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services are reimbursed at the lesser of the billed amount or the maximum allowable fee. However, PT and OT services provided by physical therapist assistants and certified occupational therapy assistants working under general supervision (after a supervision waiver is obtained) are reimbursed at the lesser of the billed amount or 90% of the maximum allowable fee.

Collecting Payment From Members

Topic #227

Conditions That Must Be Met

A member may request a noncovered service, a covered service for which PA (prior authorization) was denied (or modified), or a service that is not covered under the member's limited benefit category. The charge for the service may be collected from the member if the following conditions are met **prior** to the delivery of that service:

- The member accepts responsibility for payment.
- The provider and member make payment arrangements for the service.

Providers are strongly encouraged to obtain a **written** statement in advance documenting that the member has accepted responsibility for the payment of the service.

Furthermore, the service must be separate or distinct from a related, covered service. For example, a vision provider may provide a member with eyeglasses but then, upon the member's request, provide and charge the member for anti-glare coating, which is a noncovered service. Charging the member is permissible in this situation because the anti-glare coating is a separate service and can be added to the lenses at a later time.

Topic #538

Cost Sharing

According to federal regulations, providers cannot hold a member responsible for any commercial or Medicare cost-sharing amount such as coinsurance, copay, or deductible. Therefore, a provider may not collect payment from a member, or authorized person acting on behalf of the member, for copays required by other health insurance sources. Instead, the provider should collect from the member **only** the Medicaid or BadgerCare Plus copay amount indicated on the member's remittance information.

Topic #224

Situations When Member Payment is Allowed

Providers may not collect payment from a member, or authorized person acting on behalf of the member, **except** for the following:

- Required member copays for certain services.
- Other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) payments made to the member.
- Spenddown.
- Charges for a private room in a nursing home if meeting the requirements stated in Wis. Admin. Code § DHS 107.09(4)(k), or in a hospital if meeting the requirements stated in Wis. Admin. Code § DHS 107.08(3)(a)2.
- Noncovered services if certain conditions are met.
- Covered services for which PA (prior authorization) was denied (or an originally requested service for which a PA request was modified) if certain conditions are met. These services are treated as noncovered services.
- Services provided to a member in a limited benefit category when the services are not covered under the limited benefit and

if certain conditions are met.

If a provider inappropriately collects payment from a member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid enrollment.

Copayment

Topic #2708

Amounts

BadgerCare Plus and Medicaid

Copay amounts for PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services under BadgerCare Plus and Medicaid are determined per procedure code and correspond to the maximum allowable fee for the procedure code. Providers should use the following chart and their maximum allowable fee schedule to determine copay amounts.

Medicaid Reimbursement (per procedure code)	Copay
Up to $10	$0.50
From $10.01 to $25	$1
From $25.01 to $50	$2
Over $50	$3

Topic #231

Exemptions

Wisconsin Medicaid and BadgerCare Plus Copay Exemptions

According to Wis. Admin. Code § DHS 104.01(12)(a), and 42 C.F.R. (Code of Federal Regulations) § 447.56, providers are prohibited from collecting any copays from these Medicaid and BadgerCare Plus members:

- Children under age 19
- American Indians or Alaskan Natives, regardless of age or income level, who are receiving or have ever received items and services either directly from an Indian health care provider or through referral under contract health services
  - Note: Until further notice, Wisconsin Medicaid and BadgerCare Plus will apply this exemption policy for **all** services regardless of whether a tribal health care provider or a contracted entity provides the service. Providers may not collect copay from any individual identified in the EVS (Enrollment Verification System) as an American Indian or Alaskan Native.
- Terminally ill individuals receiving hospice care
- Nursing home residents
- Members enrolled in Wisconsin Well Woman Medicaid
- Individuals eligible through EE (Express Enrollment)

These services do not require copays from any member enrolled in Wisconsin Medicaid or BadgerCare Plus:

- Behavioral treatment
- Care coordination services (prenatal and child care coordination)
- CRS (Community Recovery Services)
- Crisis intervention services
- CSP (Community support program) services

- Comprehensive community services
- Emergency services for medical conditions that meet the prudent layperson standard
  - Note: The prudent layperson standard is defined by 42 C.F.R. (Code of Federal Regulations) § 438.114, and may be expanded to include a psychiatric emergency involving a significant risk or serious harm to oneself or others, a substance abuse emergency in which there is significant risk of serious harm to a member or others or there is likelihood of return to substance abuse without immediate treatment, or emergency dental care, which is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever, or trauma.
- EMTALA (Emergency Medical Treatment and Labor Act)-required medical screening exam and stabilization services
- Family planning services and supplies, including sterilizations
- HealthCheck services
- Home care services (home health, personal care, and PDN (private duty nurse) services)
- Hospice care services
- Immunizations, including approved vaccines recommended to adults by the ACIP (Advisory Committee on Immunization Practices)
- Independent laboratory services
- Injections
- IOP (intensive outpatient program) services
- Pregnancy-related services
- Preventive services with an A or B rating* from the USPSTF (U.S. Preventive Services Task Force)**, including tobacco cessation services
- SBS (School-based services)
- Substance abuse day treatment services
- Surgical assistance
- Targeted case management services

Note: Providers may not impose cost sharing for health-care acquired conditions or other provider-preventable services as defined in federal law under 42 C.F.R. § 447.26(b).

* Providers are required to add CPT (Current Procedural Terminology) modifier 33 to identify USPSTF services that are not specifically identified as preventive in nature. The definition for modifier 33 reads:

> When the primary purpose of the service is the delivery of an evidence based service in accordance with a U.S. Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

Since many of the USPSTF recommendations are provided as part of a regular preventive medicine visit, ForwardHealth will not deduct a copay for these services (CPT procedure codes 99381–99387 and 99391–99397).

** The USPSTF recommendations include:

- Screening tests
- Counseling
- Immunizations
- Preventive medications for targeted populations

These services must be provided or recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice.

Topic #233

Limitations

Providers should verify that they are collecting the correct copay for services as some services have monthly or annual copay limits. Providers may not collect member copays in amounts that exceed copay limits.

Monthly Copay Limits

Per the federal limitations on premiums and cost sharing in 42 C.F.R. § 447.56(f), the combined amount of Medicaid premiums and copays a BadgerCare Plus or Medicaid member incurs each month may not exceed 5% of the member's monthly household income. To comply with federal limitations on premiums and cost sharing, ForwardHealth calculates each member's monthly premium and copay limit, which is a maximum allowable copay amount based on monthly income, for individual members. Members within the same household may have different individual copay limits, and children under age 19 are exempt from copays.

Providers must determine whether or not a BadgerCare Plus or Medicaid member is exempt from paying copays or has reached their monthly copay limit by accessing the Enrollment Verification System and receiving the message "No Copay" in response to an enrollment query.

Member Notification

Each member receives a letter in the mail that states their individual monthly copay limit. If a member has a change, such as a change in income or marital status, they will receive a letter with the updated individual monthly copay limit.

When a member reaches their monthly copay limit before the end of the month, they will receive a letter that informs them that they have met their copay limit for that month, and copays will resume on the first day of the following month.

Copay Collection

Once a member meets their individual monthly copay limit, copays will no longer be deducted from the provider's reimbursement. This is true even if subsequent claim adjustments reduce the member's incurred copay amount to below their monthly limit. **Providers may not collect copays from members who have met their individual monthly copay limit.**

Topic #2707

BadgerCare Plus and Medicaid

Wisconsin Medicaid does not deduct copayment after the first 30 hours or $1,500 of reimbursement for PT (physical therapy), OT (occupational therapy), or SLP (speech and language pathology) services per calendar year, per member for members enrolled in BadgerCare Plus and Medicaid. Copay limits are calculated separately for each therapy discipline.

The copay maximum applies to each member, regardless of the number of providers. For example, if a member receives PT services from more than one provider, the copay maximum may be reached sooner than an individual provider's records indicate.

When a member has met the copay maximum, Wisconsin Medicaid does not deduct any copay from the reimbursement to the provider. If the provider collects copay beyond the copay maximum, the provider is required to return or credit the member for the extra amount.

Topic #237

Refund/Collection

If a provider collects a copay before providing a service and BadgerCare Plus does not reimburse the provider for any part of the service, the provider is required to return or credit the entire copay amount to the member.

If BadgerCare Plus deducts less copay than the member paid, the provider is required to return or credit the remainder to the member. If BadgerCare Plus deducts more copay than the member paid, the provider may collect the remaining amount from the member.

Topic #239

Requirements

Federal law permits states to charge members a copay for certain covered services. Providers are required to request copays from members. Providers may not deny services to a Wisconsin Medicaid or BadgerCare Plus member who fails to make a copay.

Wis. Stat. § 49.45(18) requires providers to make a reasonable attempt to collect copay from the member unless the provider determines that the cost of collecting the copay exceeds the amount to be collected.

Reimbursement Not Available

Topic #2706

Reimbursement Not Available

Wisconsin Medicaid may deny or recoup payment for covered services that fail to meet program requirements. Medicaid reimbursement is also not available for noncovered services.

The following are **not** reimbursable as PT (physical therapy), OT (occupational therapy), or SLP (speech and language pathology) services:

- Group SLP for services other than expressive language, hearing auditory training, or receptive language
- Facilitated communication
- Auditory integration training
- Services provided for the general good and welfare of members, including the following:
  - General exercises to promote overall fitness and flexibility
  - Activities to provide diversion or general motivation
- Crafts and other supplies used in OT services for members in an inpatient program
- Formal educational services in academic and vocational subjects
- Per Wis. Admin. Code § DHS 107.24(5)(a), certain foot orthoses or orthopedic or corrective shoes
- DME (Durable medical equipment) that are not primarily medical in nature.

Topic #695

Reimbursement Not Available Through a Factor

BadgerCare Plus will not reimburse providers through a factor, either directly or by virtue of a power of attorney given to the factor by the provider. A factor is an organization (for example, a collection agency) or person who advances money to a provider for the purchase or transferal of the provider's accounts receivable. The term "factor" does not include business representatives, such as billing services, clearinghouses, or accounting firms, which render statements and receive payments in the name of the provider.

Topic #51

Services Not Separately Reimbursable

If reimbursement for a service is included in the reimbursement for the primary procedure or service, it is not separately reimbursable. For example, routine venipuncture is not separately reimbursable, but it is included in the reimbursement for the laboratory procedure or the laboratory test preparation and handling fee. Also, DME (durable medical equipment) delivery charges are included in the reimbursement for DME items.

Topic #2705

Non-Face-to-Face Time

Only face-to-face time for PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services may be reimbursed by Wisconsin Medicaid. Non-face-to-face time is considered part of the provider's overhead cost and is not separately reimbursable. This includes, but is not limited to, the following:

- Communicating with other professionals, staff, or caregivers
- Reviewing records, scoring evaluation tests, or writing reports
- Travel time and expenses related to delivery of services, including services provided in a Birth to 3 member's natural environment

Member Information

6

Archive Date:07/01/2025

Member Information:Enrollment Categories

Topic #225

BadgerCare Plus

Populations Eligible for BadgerCare Plus

The following populations are eligible for BadgerCare Plus:

- Parents and caretakers with incomes at or below 100% of the FPL (Federal Poverty Level).
- Pregnant women with incomes at or below 300% of the FPL.
- Children (ages 18 and younger) with household incomes at or below 300% of the FPL.
- Childless adults with incomes at or below 100% of the FPL.
- Transitional medical assistance individuals, also known as members on extensions, with incomes over 100% of the FPL.

Where available, BadgerCare Plus members are enrolled in BadgerCare Plus HMOs. In those areas of Wisconsin where HMOs are not available, services will be reimbursed on a fee-for-service basis.

Premiums

The following members are required to pay premiums to be enrolled in BadgerCare Plus:

- Transitional medical assistance individuals with incomes over 133% of the FPL. Transitional medical assistance individuals with incomes between 100 and 133% FPL are exempt from premiums for the first six months of their eligibility period.
- Children (ages 18 and younger) with household incomes greater than 200% with the following exceptions:
  - Children under age 1 year.
  - Children who are tribal members or otherwise eligible to receive Indian Health Services.

Topic #16677

BadgerCare Plus Benefit Plan Changes

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

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

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

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

Topic #785

BadgerCare Plus Prenatal Program

As a result of 2005 Wisconsin Act 25, BadgerCare has expanded coverage to the following individuals:

- Pregnant non-U.S. citizens who are not qualified aliens but meet other eligibility criteria for BadgerCare.
- Pregnant individuals detained by legal process who meet other eligibility criteria for BadgerCare.

The BadgerCare Plus Prenatal Program is designed to provide better birth outcomes.

Women are eligible for all covered services from the first of the month in which their pregnancy is verified or the first of the month in which the application for BadgerCare Plus is filed, whichever is later. Members are enrolled through the last day of the month in which they deliver or the pregnancy ends. Postpartum care is reimbursable **only** if provided as part of global obstetric care. Even though enrollment is based on pregnancy, these women are eligible for **all** covered services. (They are not limited to pregnancy-related services.)

These women are not presumptively eligible. Providers should refer them to the appropriate income maintenance or tribal agency where they can apply for this coverage.

Fee-for-Service

Pregnant non-U.S. citizens who are not qualified aliens and pregnant individuals detained by legal process receive care only on a fee-for-service basis. Providers are required to follow all program requirements (for example, claim submission procedures, PA (prior authorization) requirements) when providing services to these women.

Emergency Services for Non-U.S. Citizens

When BadgerCare Plus enrollment ends for pregnant non-U.S. citizens who are not qualified aliens, they receive coverage for emergency services. These women receive emergency coverage for 60 days after the pregnancy ends; this coverage continues through the end of the month in which the 60th day falls (for example, a woman who delivers on June 20, 2006, would be enrolled through the end of August 2006).

Topic #2757

Birth to 3 Program

A child from birth up to (but not including) age three is eligible for Birth to 3 services if the child meets one of the following criteria:

- The individual has a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.
- The individual has at least a 25% delay in one or more of the following areas of development:
  - Cognitive development
  - Physical development, including vision and hearing
  - Communication skills
  - Social or emotional development
  - Adaptive development, which includes self-help skills
- Atypical development affecting the child's overall development, as determined by a qualified team using professionally acceptable procedures and informed clinical opinion.

ForwardHealth provides Birth to 3 information because many children enrolled in the Birth to 3 Program are also BadgerCare Plus/Medicaid members.

Topic #230

Express Enrollment for Children and Pregnant Women

The EE (Express Enrollment) for Pregnant Women Benefit is a limited benefit category that allows a pregnant woman to receive immediate pregnancy-related outpatient services while her application for full-benefit BadgerCare Plus is processed. Enrollment is not restricted based on the member's other health insurance coverage. Therefore, a pregnant woman who has other health insurance may be enrolled in the benefit.

The EE for Children Benefit allows certain members through 18 years of age to receive BadgerCare Plus benefits while an application for BadgerCare Plus is processed.

Fee-for-Service

Women and children who are temporarily enrolled in BadgerCare Plus through the EE process are not eligible for enrollment in an HMO until they are determined eligible for full benefit BadgerCare Plus by the income maintenance or tribal agency.

Topic #226

Family Planning Only Services

Family Planning Only Services is a limited benefit program that provides routine contraceptive management or related services to low-income individuals who are of childbearing/reproductive age (typically 15 years of age or older) and who are otherwise not eligible for Wisconsin Medicaid or BadgerCare Plus. Members receiving Family Planning Only Services must be receiving routine contraceptive management or related services.

Note: Members who meet the enrollment criteria may receive routine contraceptive management or related services **immediately** by temporarily enrolling in Family Planning Only Services through EE (Express Enrollment).

The goal of Family Planning Only Services is to provide members with information and services to assist them in preventing pregnancy, making BadgerCare Plus enrollment due to pregnancy less likely. Providers should explain the purpose of Family Planning Only Services to members and encourage them to contact their certifying agency to determine their enrollment options if they are not interested in, or do not need, contraceptive services.

Members enrolled in Family Planning Only Services receive routine services to prevent or delay pregnancy and are not eligible for other services (for example, PT (physical therapy) services, dental services). Even if a medical condition is discovered during a family planning visit, treatment for the condition is not covered under Family Planning Only Services unless the treatment is identified in the list of allowable procedure codes for Family Planning Only Services.

Members are also not eligible for certain other services that are covered under Wisconsin Medicaid and BadgerCare Plus (for example, mammograms and hysterectomies). If a medical condition, other than an STD (sexually transmitted disease), is discovered during routine contraceptive management or related services, treatment for the medical condition is not covered under Family Planning Only Services.

Colposcopies and treatment for STDs are only covered through Family Planning Only Services if they are determined medically necessary during routine contraceptive management or related services. A colposcopy is a covered service when an abnormal result is received from a pap test, prior to the colposcopy, while the member is enrolled in Family Planning Only Services and receiving contraceptive management or related services.

Family Planning Only Services members diagnosed with cervical cancer, precancerous conditions of the cervix, or breast cancer

may be eligible for Wisconsin Well Woman Medicaid. Providers should assist eligible members with the enrollment process for Well Woman Medicaid.

Providers should inform members about other coverage options and provide referrals for care not covered by Family Planning Only Services.

Topic #4757

ForwardHealth and ForwardHealth interChange

ForwardHealth brings together many Wisconsin DHS (Department of Health Services) health care programs with the goal to create efficiencies for providers and to improve health outcomes for members. ForwardHealth interChange is the DHS claims processing system that supports multiple state health care programs and web services, including:

- BadgerCare Plus
- BadgerCare Plus and Medicaid managed care programs
- SeniorCare
- HDAP (Wisconsin HIV Drug Assistance Program)
- WCDP (Wisconsin Chronic Disease Program)
- WIR (Wisconsin Immunization Registry)
- Wisconsin Medicaid
- Wisconsin Well Woman Medicaid
- WWWP (Wisconsin Well Woman Program)

ForwardHealth interChange is supported by the state's fiscal agent, Gainwell Technologies.

Topic #229

Limited Benefit Categories Overview

Certain members may be enrolled in a limited benefit category. These limited benefit categories include the following:

- BadgerCare Plus Prenatal Program
- EE (Express Enrollment) for Children
- EE for Pregnant Women
- Family Planning Only Services, including EE for individuals applying for Family Planning Only Services
- QDWI (Qualified Disabled Working Individuals)
- QI-1 (Qualifying Individuals 1)
- QMB Only (Qualified Medicare Beneficiary Only)
- SLMB (Specified Low-Income Medicare Beneficiary)
- Tuberculosis-Related Medicaid

Members may be enrolled in full-benefit Medicaid or BadgerCare Plus and also be enrolled in certain limited benefit programs, including QDWI, QI-1, QMB Only, and SLMB. In those cases, a member has full Medicaid or BadgerCare Plus coverage in addition to limited coverage for Medicare expenses.

Members enrolled in the BadgerCare Plus Prenatal Program, Family Planning Only Services, EE for Children, EE for Pregnant Women, or Tuberculosis-Related Medicaid cannot be enrolled in full-benefit Medicaid or BadgerCare Plus. These members receive benefits through the limited benefit category.

Providers should note that a member may be enrolled in more than one limited benefit category. For example, a member may be

enrolled in Family Planning Only Services and Tuberculosis-Related Medicaid.

Providers are strongly encouraged to verify dates of enrollment and other coverage information using Wisconsin's EVS (Enrollment Verification System) to determine whether a member is in a limited benefit category, receives full-benefit Medicaid or BadgerCare Plus, or both.

Providers are responsible for knowing which services are covered under a limited benefit category. If a member of a limited benefit category requests a service that is not covered under the limited benefit category, the provider may collect payment from the member if certain conditions are met.

Topic #228

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for selected groups of people who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP (Wisconsin Medical Assistance Program), MA (Medical Assistance), Title XIX, or T19.

A Medicaid member is any individual entitled to benefits under Title XIX of the Social Security Act and under the Medical Assistance State Plan as defined in Wis. Stat. ch. 49.

Wisconsin Medicaid enrollment is determined on the basis of financial need and other factors. A citizen of the United States or a "qualified immigrant" who meets low-income financial requirements may be enrolled in Wisconsin Medicaid if they are in one of the following categories:

- Age 65 and older
- Blind
- Disabled

Some needy and low-income people become eligible for Wisconsin Medicaid by qualifying for programs such as:

- Katie Beckett
- Medicaid Purchase Plan
- Foster care or adoption assistance programs
- SSI (Supplemental Security Income)
- WWWP (Wisconsin Well Woman Program)

Providers may advise these individuals or their representatives to contact their certifying agency for more information. The following agencies certify people for Wisconsin Medicaid enrollment:

- Income maintenance or tribal agencies
- Medicaid outstation sites
- SSA (Social Security Administration) offices

In limited circumstances, some state agencies also certify individuals for Wisconsin Medicaid.

Medicaid fee-for-service members receive services through the traditional health care payment system under which providers receive a payment for each unit of service provided. Some Medicaid members receive services through state-contracted MCOs (managed care organizations).

Topic #232

Qualified Disabled Working Individual Members

QDWI (Qualified Disabled Working Individual) members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part A.

QDWI members are certified by their income maintenance or tribal agency. To qualify, QDWI members are required to meet the following qualifications:

- Have income under 200% of the FPL (Federal Poverty Level)
- Be entitled to, but not necessarily enrolled in, Medicare Part A
- Have income or assets too high to qualify for QMB-Only (Qualified Medicare Beneficiary-Only) and SLMB (Specified Low-Income Medicare Beneficiary)

Topic #234

Qualified Medicare Beneficiary-Only Members

QMB-Only (Qualified Medicare Beneficiary-Only) members are a limited benefit category of Medicaid members. They receive payment of the following:

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

QMB-Only members are certified by their income maintenance or tribal agency. QMB-Only members are required to meet the following qualifications:

- Have an income under 100% of the FPL (Federal Poverty Level)
- Be entitled to, but not necessarily enrolled in, Medicare Part A

Topic #235

Qualifying Individual 1 Members

QI-1 (Qualifying Individual 1) members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part B.

QI-1 members are certified by their income maintenance or tribal agency. To qualify, QI-1 members are required to meet the following qualifications:

- Have income between 120 and 135% of the FPL (Federal Poverty Level)
- Be entitled to, but not necessarily enrolled in, Medicare Part A

Topic #18777

Real-Time Eligibility Determinations

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

A member determined eligible through the real-time eligibility process will receive a temporary ID (identification) card for BadgerCare Plus and/or Family Planning Only Services. Each member will get their own card, and each card will include the member's ForwardHealth ID number. The temporary ID card will be valid for the dates listed on the card and will allow the member to get immediate health care or pharmacy services.

Eligibility Verification

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

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

Sample Temporary Identification Card for Badger Care Plus

To the Provider

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

NOTE:

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

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR BADGERCARE PLUS

SAMPLE

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

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

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

Sample 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 #236

Specified Low-Income Medicare Beneficiaries

SLMB (Specified Low-Income Medicare Beneficiary) members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part B.

SLMB members are certified by their income maintenance or tribal agency. To qualify, SLMB members are required to meet the following qualifications:

- Have an income under 120 percent of the FPL (Federal Poverty Level)
- Be entitled to, but not necessarily enrolled in, Medicare Part A

Topic #262

Tuberculosis-Related Medicaid

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

Topic #240

Wisconsin Well Woman Medicaid

Wisconsin Well Woman Medicaid provides full Medicaid benefits to underinsured or uninsured women ages 35 to 64 who have

been screened and diagnosed by WWWP (Wisconsin Well Woman Program) or Family Planning Only Services, meet all other enrollment requirements, and are in need of treatment for any of the following:

- Breast cancer
- Cervical cancer
- Precancerous conditions of the cervix

Services provided to women who are enrolled in WWWMA (Wisconsin Well Woman Medicaid) are reimbursed through Medicaid fee-for-service.

Identification Cards

Topic #266

ForwardHealth Identification Cards

Each enrolled member receives an identification card. Possession of a program identification card does not guarantee enrollment. It is possible that a member will present a card during a lapse in enrollment; therefore, it is essential that providers verify enrollment before providing services. Members are told to keep their cards even though they may have lapses in enrollment.

ForwardHealth Identification Card Features

The ForwardHealth identification card includes the member's name, 10-digit member ID, magnetic stripe, signature panel, and the Member Services telephone number. The card also has a unique, 16-digit card number on the front for internal program use.

The ForwardHealth card does not need to be signed to be valid; however, adult members are encouraged to sign their cards. Providers may use the signature as another means of identification.

The toll-free number on the back of each of the cards is for member use only. The address on the back of each card is used to return a lost card to ForwardHealth if it is found.

If a provider finds discrepancies with the identification number or name between what is indicated on the ForwardHealth card and the provider's file, the provider should verify enrollment with Wisconsin's EVS (Enrollment Verification System).

Digital ForwardHealth Identification Cards

Members can access digital versions of their ForwardHealth cards on the MyACCESS mobile app. Members are able to save PDFs and print out paper copies of their cards from the app. The digital and paper printout versions of the cards are identical to the physical cards for the purposes of accessing Medicaid-covered services. All policies that apply to the physical cards mailed by ForwardHealth to the member also apply to the digital or printed versions that members may present.

A member may still access their digital ForwardHealth card on the MyACCESS app when they are no longer enrolled. The MyACCESS app will display a banner message noting that the member is not currently enrolled in a ForwardHealth program. Providers should always verify enrollment with Wisconsin's EVS.

Identification Number Changes

Some providers may question whether services should be provided if a member's 10-digit identification number on their ForwardHealth card does not match the EVS response. If the EVS indicates the member is enrolled, services should be provided.

A member's identification number may change, and the EVS will reflect that change. However, ForwardHealth does not automatically send a replacement ForwardHealth card with the new identification number to the member. ForwardHealth cross-references the old and new identification numbers so a provider may submit claims with either number. The member may request a replacement ForwardHealth card that indicates the new number.

Member Name Changes

If a member's name on the ForwardHealth card is different than the response given from Wisconsin's EVS, providers should use

the name from the EVS response. When a name change is reported and on file, a new card will automatically be sent to the member.

Deactivated Cards

When any member identification card has been replaced for any reason, the previous identification card is deactivated. If a member presents a deactivated card, providers should encourage the member to discard the deactivated card and use only the new card.

Although a member identification card may be deactivated, the member ID is valid and the member still may be enrolled in a ForwardHealth program.

If a provider swipes a ForwardHealth card using a magnetic stripe card reader and finds that it has been deactivated, the provider may request a second form of identification if they do not know the member. After the member's identity has been verified, providers may verify a member's enrollment by using one of the EVS methods such as AVR (Automated Voice Response).

Defective Cards

If a provider uses a card reader for a ForwardHealth card and the magnetic stripe is defective, the provider should encourage the member to call Member Services at the number listed on the back of the member's card to request a new card.

If a member presents a ForwardHealth card with a defective magnetic stripe, providers may verify the member's enrollment by using an alternate enrollment verification method. Providers may also verify a member's enrollment by entering the member ID or 16-digit card number on a touch pad, if available, or by calling WiCall or Provider Services.

Lost Cards

If a member needs a replacement ForwardHealth card, they may call Member Services to request a new one.

If a member lost their ForwardHealth card or never received one, the member may call Member Services to request a new one.

Managed Care Organization Enrollment Changes

Members do not receive a new ForwardHealth card if they are enrolled in a state-contracted MCO (managed care organization) or change from one MCO to another. Providers should verify enrollment with the EVS every time they see a member to ensure they have the most current managed care enrollment information.

Topic #1435

Types of Identification Cards

ForwardHealth members receive an identification card upon initial eligibility determination. Identification cards may be presented in different formats (for example, white plastic cards, paper cards, or paper printouts), depending on the program and the method used to enroll (for example, paper application or online application). Members who are temporarily enrolled in BadgerCare Plus or Family Planning Only Services receive temporary identification cards.

Enrollment Rights

Topic #246

Appealing Enrollment Determinations

Applicants and members have the right to appeal certain decisions relating to BadgerCare Plus, Medicaid, or HDAP (Wisconsin HIV Drug Assistance Program) enrollment. An applicant, a member, or authorized person acting on behalf of the applicant or member, or former member may file the appeal with the DHA (Division of Hearings and Appeals).

Pursuant to Wis. Admin. Code § HA 3.03, an applicant, member, or former member may appeal any adverse action or decision by an agency or department that affects their benefits. Examples of decisions that may be appealed include, but are not limited to, the following:

- Individual was denied the right to apply.
- Application for BadgerCare Plus, HDAP, or Wisconsin Medicaid was denied.
- Application for BadgerCare Plus, HDAP, or Wisconsin Medicaid was not acted upon promptly.
- Enrollment was unfairly discontinued, terminated, suspended, or reduced.

In the case when enrollment is cancelled or terminated, the date the member, or authorized person acting on behalf of the member, files an appeal with the DHA determines what continuing coverage, if any, the member will receive until the hearing decision is made. The following scenarios describe the coverage allowed for a member who files an appeal:

- If a member files an appeal before his or her enrollment ends, coverage will continue pending the hearing decision.
- If a member files an appeal within 45 days after his or her enrollment ends, a hearing is allowed but coverage is not reinstated.

If the member files an appeal more than 45 days after his or her enrollment ends, a hearing is not allowed. Members may file an appeal by submitting a Request for Fair Hearing (DHA-28 (08/09)) form.

Claims for Appeal Reversals

Claim Denial Due to Termination of BadgerCare Plus or Wisconsin Medicaid Enrollment

If a claim is denied due to termination of BadgerCare Plus or Wisconsin Medicaid enrollment, a hearing decision that reverses that determination will allow the claim to be resubmitted and paid. The provider is required to obtain a copy of the appeal decision from the member, attach the copy to the previously denied claim, and submit both to ForwardHealth at the following address:

ForwardHealth
Specialized Research
Ste 50
313 Blettner Blvd
Madison WI 53784

If a provider has not yet submitted a claim, the provider is required to submit a copy of the hearing decision along with a paper claim to Specialized Research.

As a reminder, claims submission deadlines still apply even to those claims with hearing decisions.

Claim Denial Due to Termination of HDAP Enrollment

If a claim is denied due to termination of HDAP enrollment, a hearing decision that reverses that determination will allow the claim to be resubmitted and paid. The provider is required to obtain a copy of the appeal decision from the member, attach the copy to the previously denied claim, and submit both to ForwardHealth at the following address:

ForwardHealth
HDAP Claims and Adjustments
PO Box 8758
Madison WI 53708

If a provider has not yet submitted a claim, the provider is required to submit a copy of the hearing decision along with a paper claim to HDAP Claims and Adjustments.

As a reminder, claims submission deadlines still apply even to those claims with hearing decisions.

Topic #247

Freedom of Choice

Members may receive covered services from **any** willing Medicaid-enrolled provider, unless they are enrolled in a state-contracted MCO (managed care organization) or assigned to the Pharmacy Services Lock-In Program.

Topic #248

General Information

Members are entitled to certain rights per Wis. Admin. Code ch. DHS 103.

Topic #250

Notification of Discontinued Benefits

When DHS (Department of Health Services) intends to discontinue, suspend, or reduce a member's benefits, or reduce or eliminate coverage of services for a general class of members, DHS sends a written notice to members. This notice is required to be provided at least 10 days before the effective date of the action.

Topic #252

Prompt Decisions on Enrollment

Individuals applying for BadgerCare Plus or Wisconsin Medicaid have the right to prompt decisions on their applications. Enrollment decisions are made within 60 days of the date the application was signed for those with disabilities and within 30 days for all other applicants.

Topic #254

Requesting Retroactive Enrollment

An applicant has the right to request retroactive enrollment when applying for BadgerCare Plus or Wisconsin Medicaid. Enrollment may be backdated to the first of the month three months prior to the date of application for eligible members. Retroactive enrollment does not apply to QMB-Only (Qualified Medicare Beneficiary-Only) members.

Enrollment Responsibilities

Topic #241

General Information

Members have certain responsibilities per Wis. Admin. Code § DHS 104.02 and the ForwardHealth Enrollment and Benefits (P-00079 (07/14)) booklet.

Topic #243

Loss of Enrollment — Financial Liability

Some covered services consist of a series of sequential treatment steps, meaning more than one office visit is required to complete treatment.

In most cases, if a member loses enrollment midway through treatment, BadgerCare Plus and Medicaid will **not** reimburse services (including prior authorized services) after enrollment has lapsed.

Members are financially responsible for any services received after their enrollment has been terminated. If the member wishes to continue treatment, it is a decision between the provider and the member whether the service should be given and how the services will be paid. The provider may collect payment from the member if the member accepts responsibility for payment of a service and certain conditions are met.

To avoid misunderstandings, it is recommended that providers remind members that they are financially responsible for any continued care after enrollment ends.

To avoid potential reimbursement problems that can arise when a member loses enrollment midway through treatment, the provider is encouraged to verify the member's enrollment using the EVS (Enrollment Verification System) or the ForwardHealth Portal prior to providing each service, even if an approved PA (prior authorization) request is obtained for the service.

Topic #707

Member Cooperation

Members are responsible for giving providers full and accurate information necessary for the correct submission of claims. If a member has other health insurance, it is the member's obligation to give full and accurate information to providers regarding the insurance.

Topic #269

Members Should Present Card

It is important that providers determine a member's enrollment and other insurance coverage **prior to** each DOS (date of service) that services are provided. Pursuant to Wis. Admin. Code § DHS 104.02(2), a member should inform providers that they are enrolled in BadgerCare Plus or Wisconsin Medicaid and should present a current ForwardHealth identification card before

receiving services.

Note: Due to the nature of their specialty, certain providers — such as anesthesiologists, radiologists, DME (durable medical equipment) suppliers, independent laboratories, and ambulances — are not always able to see a member's ForwardHealth identification card because they might not have direct contact with the member prior to providing the service. In these circumstances, it is still the provider's responsibility to obtain member enrollment information.

Topic #244

Prior Identification of Enrollment

Except in emergencies that preclude prior identification, members are required to inform providers that they are receiving benefits and must present their ForwardHealth identification card before receiving care. If a member forgets their ForwardHealth card, providers may verify enrollment without it.

Topic #245

Reporting Changes to Caseworkers

Members are required to report certain changes to their caseworker at their certifying agency. These changes include, but are not limited to, the following:

- A new address or a move out of state
- A change in income
- A change in family size, including pregnancy
- A change in other health insurance coverage
- Employment status
- A change in assets for members who are over 65 years of age, blind, or disabled

Special Enrollment Circumstances

Topic #276

Medicaid Members From Other States

Wisconsin Medicaid does not pay for services provided to members enrolled in other state Medicaid programs. Providers are advised to contact other state Medicaid programs to determine whether the service sought is a covered service under that state's Medicaid program.

Topic #279

Members Traveling Out of State

When a member travels out of state but is within the United States (including its territories), Canada, or Mexico, BadgerCare Plus and Wisconsin Medicaid cover medical services in any of the following circumstances:

- An emergency illness or accident
- When the member's health would be endangered if treatment were postponed
- When the member's health would be endangered if travel to Wisconsin were undertaken
- When PA (prior authorization) has been granted to the provider for provision of a nonemergency service
- When there are coinsurance, copay, or deductible amounts remaining after Medicare payment or approval for dual eligibles

Travel expenses such as lodging or food are not reimbursable by Wisconsin Medicaid.

Note: Some providers located in a state that borders Wisconsin may be Wisconsin Medicaid enrolled as a border-status provider if the provider notifies ForwardHealth in writing that it is common practice for members in a particular area of Wisconsin to seek their medical services. Border-status providers follow the same policies as Wisconsin providers.

Topic #277

Non-U.S. Citizens — Emergency Services

Certain non-U.S. citizens who are not qualified aliens are eligible for services only in cases of acute emergency medical conditions. Providers should use the appropriate diagnosis code to document the nature of the emergency.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of such severity that one could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the person's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Due to federal regulations, BadgerCare Plus and Wisconsin Medicaid do not cover services for non-U.S. citizens who are not qualified aliens related to routine prenatal or postpartum care, major organ transplants (for example, heart, liver), or ongoing treatment for chronic conditions where there is no evidence of an acute emergent state. For the purposes of this policy, services for ESRD (end-stage renal disease) and all labor and delivery are considered emergency services.

Note: Babies born to certain non-qualifying immigrants are eligible for Medicaid enrollment under the CEN (continuously eligible newborn) option. However, babies born to women with incomes over 300 percent of the FPL (Federal Poverty Level) are not eligible for CEN status. The baby may still qualify for BadgerCare Plus. These mothers should report the birth to the local agencies within 10 calendar days.

A provider who gives emergency care to a non-U.S. citizen should refer them to the income maintenance or tribal agency or ForwardHealth outstation site for a determination of BadgerCare Plus enrollment. Providers may complete the Certification of Emergency for Non-U.S. Citizens (F-01162 (02/2009)) form for clients to take to the income maintenance or tribal agency in their county of residence where the BadgerCare Plus enrollment decision is made.

Providers should be aware that a client's enrollment does not guarantee that the services provided will be reimbursed by BadgerCare Plus.

Topic #278

Persons Detained by Legal Process

Most individuals detained by legal process who are eligible for BadgerCare Plus or Wisconsin Medicaid benefits will have their eligibility suspended during their detention period. During the suspension, ForwardHealth will only cover inpatient services received while the member is outside of jail or prison for 24 hours or more.

Note: Detained by legal process means a person who is incarcerated because of law violation or alleged law violation, which includes misdemeanors, felonies, delinquent acts, and day-release prisoners. Inmates who are released from jail under the Huber Program to return home to care for their minor children may be eligible for full benefit BadgerCare Plus or Wisconsin Medicaid without suspension.

Pregnant women detained by legal process who qualify for the BadgerCare Plus Prenatal Program and state prison inmates who qualify for Wisconsin Medicaid or BadgerCare Plus during inpatient hospital stays may receive certain benefits and are not subject to eligibility suspension. Additionally, inmates of county jails admitted to a hospital for inpatient services who are expected to remain in the hospital for 24 hours or more will be eligible for PE (presumptive eligibility) determinations for BadgerCare Plus by qualified hospitals. Refer to the Presumptive Eligibility chapter of either the Inpatient or Outpatient Hospital service area for more information on the PE determination process.

The DOC (Department of Corrections) or county jail oversee health care-related needs for individuals detained by legal process who do not qualify for the BadgerCare Plus Prenatal Program or for state prison inmates who do not qualify for Wisconsin Medicaid or BadgerCare Plus during an inpatient hospital stay.

Topic #16657

State Prison Inmates May Qualify for BadgerCare Plus or Wisconsin Medicaid During Inpatient Hospital Stays

As a result of 2013 Wisconsin Act 20, state prison inmates may qualify for BadgerCare Plus or Wisconsin Medicaid during inpatient hospital stays.

Eligibility

Most individuals detained by legal process who are eligible for BadgerCare Plus or Wisconsin Medicaid benefits will have their eligibility suspended during their detention period. During the suspension, ForwardHealth will only cover inpatient services received while the member is outside of jail or prison for 24 hours or more.

To qualify for BadgerCare Plus or Wisconsin Medicaid, prison or jail inmates must meet all applicable eligibility criteria. The DOC coordinates and reimburses inpatient hospital services for state prison inmates who do not qualify for BadgerCare Plus or Wisconsin Medicaid.

Inmates whose BadgerCare Plus or Wisconsin Medicaid eligibility has been suspended will have coverage of inpatient services for the duration of a hospital stay of 24 hours or more. This coverage begins on their date of admission and ends on their date of discharge.

Inmates are not eligible for outpatient hospital services, including observations, under BadgerCare Plus and Wisconsin Medicaid. Inmates may only be eligible for ER (emergency room) services if they are admitted to the hospital directly from the ER and are counted in the midnight census; otherwise, ER services are considered outpatient services. Outpatient hospital services approved by the DOC are reimbursed by the DOC.

Inmates are not presumptively eligible. Retroactive eligibility will only apply to dates of admission on and after April 1, 2014.

Enrollment

The DOC coordinates the submission of enrollment applications on behalf of state prison inmates.

Covered Services

The only services allowable by BadgerCare Plus or Wisconsin Medicaid for inmates are inpatient hospital services and professional services provided during the inpatient hospital stay that are covered under BadgerCare Plus and Wisconsin Medicaid. Providers with questions regarding services covered by BadgerCare Plus and Wisconsin Medicaid may refer to the applicable service area or contact Provider Services.

Fee-for-Service

Inmates receive services on a fee-for-service basis; they are not enrolled in HMOs.

HMO

BadgerCare Plus and Medicaid SSI members who are incarcerated for 30 or more calendar days will be automatically enrolled in fee-for-service Medicaid. These members will be removed from their previous enrollment in BadgerCare Plus and Medicaid SSI HMOs. Members are identified as incarcerated if their circumstance meets the federal definition of inmate of a public institution, per 42 C.F.R. § 435.1010.

When ForwardHealth is made aware of a member's incarceration status being longer than 30 days, it will retroactively disenroll that member from any HMO. Medicaid fee-for-service coverage will begin the first day of the month when the member's incarceration began. For example, if a member was incarcerated on October 10, HMO enrollment will be end-dated effective September 30, and fee-for-service enrollment will be effective October 1.

ForwardHealth can disenroll a member from their HMO retroactive to as many as 12 months.

Members incarcerated for less than 30 days will remain enrolled in their HMOs. However, providers must bill any inpatient hospital stays and professional services associated with hospital stays for these members to fee-for-service Medicaid. These claims must be submitted as extraordinary claims.

Prior Authorization

The DOC will assist inpatient hospital providers with their submission of PA (prior authorization) requests for any services requiring PA. If PA is denied, the DOC is responsible for reimbursement of the services.

Enrollment Verification

Inmates are only enrolled for the duration of their hospital stay. Providers should always verify an inmate's enrollment in BadgerCare Plus or Wisconsin Medicaid before submitting a claim.

Claim Submission

When submitting a claim for an inmate's inpatient hospital stay, providers should follow the current claim submission procedures for each applicable service area.

Reimbursement

Acute care hospitals that provide services to inmates are reimbursed at a percentage of their usual and customary charge.

Critical access hospitals that provide services to inmates are reimbursed according to their existing Wisconsin Medicaid reimbursement methodology.

Wisconsin Medicaid reimburses professional services related to an inmate's inpatient hospital stay (for example, laboratory services, physician services, radiology services, or DME (durable medical equipment)) at the current maximum allowable fee.

Contact Information

Providers may contact the DOC at 608-240-5139 or 608-240-5190 with questions regarding enrollment or PA for inmate inpatient hospital stays.

Topic #280

Retroactive Enrollment

Retroactive enrollment occurs when an individual has applied for BadgerCare Plus or Medicaid and enrollment is granted with an effective date prior to the date the enrollment determination was made. A member's enrollment may be backdated to allow retroactive coverage for medical bills incurred prior to the date of application.

The retroactive enrollment period may be backdated up to three months prior to the month of application if all enrollment requirements were met during the period. Enrollment may be backdated more than three months if there were delays in determining enrollment or if court orders, fair hearings, or appeals were involved.

Reimbursing Members in Cases of Retroactive Enrollment

When a member receives retroactive enrollment, he or she has the right to request the return of payments made to a Medicaid-enrolled provider for a covered service during the period of retroactive enrollment, according to Wis. Admin. Code § DHS 104.01(11). A Medicaid-enrolled provider is required to submit claims to ForwardHealth for covered services provided to a member during periods of retroactive enrollment. Medicaid cannot directly refund the member.

If a service(s) that requires PA (prior authorization) was performed during the member's period of retroactive enrollment, the provider is required to submit a PA request and receive approval from ForwardHealth **before** submitting a claim.

If a provider receives reimbursement from Medicaid for services provided to a retroactively enrolled member and the member has paid for the service, the provider is required to reimburse the member or authorized person acting on behalf of the member (for example, local General Relief agency) the full amount that the member paid for the service.

If a claim cannot be filed within 365 days of the DOS (date of service) due to a delay in the determination of a member's retroactive enrollment, the provider is required to submit the claim to Timely Filing within 180 days of the date the retroactive enrollment is entered into Wisconsin's EVS (Enrollment Verification System) (if the services provided during the period of retroactive enrollment were covered).

Topic #281

Spenddown to Meet Financial Enrollment Requirements

Occasionally, an individual with significant medical bills meets all enrollment requirements except those pertaining to income. These individuals are required to "spenddown" their income to meet financial enrollment requirements.

The certifying agency calculates the individual's spenddown (or deductible) amount, tracks all medical costs the individual incurs, and determines when the medical costs have satisfied the spenddown amount. (A payment for a medical service does not have to be made by the individual to be counted toward satisfying the spenddown amount.)

When the individual meets the spenddown amount, the certifying agency notifies ForwardHealth and the provider of the last service that the individual is eligible beginning on the date that the spenddown amount was satisfied.

If the individual's last medical bill is greater than the amount needed to satisfy the spenddown amount, the certifying agency notifies the affected provider by indicating the following:

- The individual is eligible for benefits as of the DOS (date of service) on the last bill.
- A claim for the service(s) on the last bill should be submitted to ForwardHealth. (The claim should indicate the full cost of the service.)
- The portion of the last bill that the individual must pay to the provider.

The certifying agency also informs ForwardHealth of the individual's enrollment and identifies the following:

- The DOS of the final charges counted toward satisfying the spenddown amount
- The provider number of the provider of the last service
- The spenddown amount remaining to be satisfied

When the provider submits the claim, the spenddown amount will automatically be deducted from the provider's reimbursement for the claim. The spenddown amount is indicated in the Member's Share element on the Medicaid Remaining Deductible Update (F-10109 (02/2014)) form sent to providers by the member's certifying agency. The provider's reimbursement is then reduced by the amount of the member's obligation.

Topic #23277

12-Month Continuous Health Care Coverage for Children

Most children enrolled in BadgerCare Plus or Medicaid programs will keep their health insurance coverage for 12 months. Even if their family has a change in income or other circumstances, children under age 19 will have coverage at least until their next renewal. This policy is required by the federal Consolidated Appropriations Act, 2023.

Children enrolled in Foster Care Medicaid or SSI Medicaid will have 12-months of continuous coverage even if their out-of-home placement, subsidized guardianship, court-ordered kinship care, adoption assistance agreement, or SSI payment ends.

Qualifying Programs

Members under age 19 in the following programs qualify for continuous coverage:

- BadgerCare Plus
- Emergency Services Medicaid
- Family Planning Only Services
- Foster Care Medicaid
- HCBW (Home and Community-Based Waiver) Medicaid
- Institutional Medicaid
- Katie Beckett Medicaid
- MAPP (Medicaid Purchase Plan)
- Medicare Savings Programs
- Special Status Medicaid
- SSI (Supplemental Security Income)-Related Medicaid
- SSI Medicaid
- Tuberculosis-Related Medicaid
- Wisconsin Well Woman Medicaid

Exceptions to Continuous Coverage

Continuous coverage does not apply to children:

- Enrolled under presumptive eligibility, also known as Express Enrollment.
- Enrolled by meeting a deductible. These are members who become eligible for up to a six-month period based on their medical expenses.

Children remain eligible for the 12 months until their next renewal unless:

- They turn 19.
- They move out of Wisconsin.
- Their citizenship or immigration status is not verified.
- Their eligibility was based on inaccurate information or agency error.
- The family asks to end their coverage.

Assisting Members Through Enrollment Renewals

Helping families through the health care renewal process remains vital to keeping children covered. Providers are asked to remind BadgerCare Plus and other Wisconsin Medicaid program members to renew their coverage, even if they think their situation will change in the future. Members should also be reminded to tell their agency about any changes to their address, phone number, or email to ensure they continue to receive important information about their health care coverage from Wisconsin DHS (Department of Health Services).

Member Resources

Free Health Insurance Application and Renewal Assistance

Members who need help with applying for or renewing health care coverage can access the following resources:

- Covering Wisconsin (free expert help with health insurance), available at the WisCovered website
- 211 Wisconsin at 211 or 877-947-2211

Continuous Coverage and Health Care Renewal Information

Additional member resources regarding health care renewals and continuous coverage for children are available:

- Medicaid: Programs for Children web page
- Health Care Renewals web page
- "Keeping Kids Covered" 12-Month Continuous Coverage for Children fact sheet
- BadgerCare Plus: Frequently Asked Questions

Additional policy information on continuous coverage for children is available in the BadgerCare Plus Handbook.

Misuse and Abuse of Benefits

Topic #271

Examples of Member Abuse or Misuse

Examples of member abuse or misuse are included in Wis. Admin. Code § DHS 104.02(5).

Topic #274

Pharmacy Services Lock-In Program

Overview of the Pharmacy Services Lock-In Program

The purpose of the Pharmacy Services Lock-In Program is to coordinate the provision of health care services for members who abuse or misuse Medicaid, BadgerCare Plus, or SeniorCare benefits by seeking duplicate or medically unnecessary services, particularly for controlled substances. The Pharmacy Services Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in Wis. Admin. Code § DHS 104.02.

Coordination of member health care services is intended to:

- Curb the abuse or misuse of controlled substance medications.
- Improve the quality of care for a member.
- Reduce unnecessary physician utilization.

The Pharmacy Services Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in Wis. Admin. Code § DHS 104.02. The abuse and misuse definition includes:

- Not duplicating or altering prescriptions
- Not feigning illness, using false pretense, providing incorrect enrollment status, or providing false information to obtain service
- Not seeking duplicate care from more than one provider for the same or similar condition
- Not seeking medical care that is excessive or not medically necessary

The Pharmacy Services Lock-In Program applies to members in fee-for-service as well as members enrolled in Medicaid SSI HMOs and BadgerCare Plus HMOs. Members remain enrolled in the Pharmacy Services Lock-In Program for two years and are continuously monitored for their prescription drug usage. At the end of the two-year enrollment period, an assessment is made to determine if the member should continue enrollment in the Pharmacy Services Lock-In Program.

Members enrolled in the Pharmacy Services Lock-In Program will be locked into one pharmacy where prescriptions for restricted medications must be filled and one prescriber who will prescribe restricted medications. Restricted medications are most controlled substances, carisoprodol, and tramadol. Referrals will be required only for restricted medication services.

Fee-for-service members enrolled in the Pharmacy Services Lock-In Program may choose physicians and pharmacy providers from whom to receive prescriptions and medical services not related to restricted medications. Members enrolled in an HMO must comply with the HMO's policies regarding care that is not related to restricted medications.

Referrals of members as candidates for lock-in are received from retrospective DUR (Drug Utilization Review), physicians, pharmacists, other providers, and through automated surveillance methods. Once a referral is received, six months of pharmacy claims and diagnoses data are reviewed. A recommendation for one of the following courses of action is then made:

- No further action.
- Send an intervention letter to the physician.
- Send a warning letter to the member.
- Enroll the member in the Pharmacy Services Lock-In Program.

Medicaid, BadgerCare Plus, and SeniorCare members who are candidates for enrollment in the Pharmacy Services Lock-In Program are sent a letter of intent, which explains the restriction that will be applied, how to designate a primary prescriber and a pharmacy, and how to request a hearing if they wish to contest the decision for enrollment (that is, due process). If a member fails to designate providers, the Pharmacy Services Lock-In Program may assign providers based on claims' history. In the letter of intent, members are also informed that access to emergency care is not restricted.

Letters of notification are sent to the member and to the lock-in primary prescriber and pharmacy. Providers may designate alternate prescribers or pharmacies for restricted medications, as appropriate. Members remain in the Pharmacy Services Lock-In Program for two years. The primary lock-in prescriber and pharmacy may make referrals for specialist care or for care that they are otherwise unable to provide (for example, home infusion services). The member's utilization of services is reviewed prior to release from the Pharmacy Services Lock-In Program, and lock-in providers are notified of the member's release date.

Excluded Drugs

The following scheduled drugs will be excluded from monitoring by the Pharmacy Services Lock-In Program:

- Anabolic steroids
- Barbiturates used for seizure control
- Lyrica
- Provigil and Nuvigil
- Weight loss drugs

Pharmacy Services Lock-In Program Administrator

The Pharmacy Services Lock-In Program is administered by Acentra. Acentra may be contacted by phone at 877-719-3123, by fax at 800-881-5573, or by mail at the following address:

Pharmacy Services Lock-In Program
c/o Acentra
PO Box 3570
Auburn AL 36831-3570

Pharmacy Services Lock-In Prescribers Are Required to Be Enrolled in Wisconsin Medicaid

To prescribe restricted medications for Pharmacy Services Lock-In Program members, prescribers are required to be enrolled in Wisconsin Medicaid. Enrollment for the Pharmacy Services Lock-In Program is not separate from enrollment in Wisconsin Medicaid.

Role of the Lock-In Prescriber and Pharmacy Provider

The lock-in prescriber determines what restricted medications are medically necessary for the member, prescribes those

medications using their professional discretion, and designates an alternate prescriber if needed. If the member requires an alternate prescriber to prescribe restricted medications, the primary prescriber should complete the Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services (F-11183 (02/2025)) form and return it to the Pharmacy Services Lock-In Program and to the member's HMO, if applicable.

To coordinate the provision of medications, the lock-in prescriber may also contact the lock-in pharmacy to give the pharmacist (s) guidelines as to which medications should be filled for the member and from whom. The primary lock-in prescriber should also coordinate the provision of medications with any other prescribers they have designated for the member.

The lock-in pharmacy fills prescriptions for restricted medications that have been written by the member's lock-in prescriber(s) and works with the lock-in prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The lock-in pharmacy may fill prescriptions for medications from prescribers other than the lock-in prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated lock-in prescriber, the claim will be denied.

Designated Lock-In Pharmacies

The Pharmacy Services Lock-In Program pharmacy fills prescriptions for restricted medications that have been written by the member's lock-in prescriber(s) and works with the lock-in prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The lock-in pharmacy may fill prescriptions for medications from prescribers other than the lock-in prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated lock-in prescriber, the claim will be denied.

Alternate Providers for Members Enrolled in the Pharmacy Services Lock-In Program

Members enrolled in the Pharmacy Services Lock-In Program do not have to visit their lock-in prescriber to receive medical services unless an HMO requires a primary care visit. Members may see other providers to receive medical services; however, other providers cannot prescribe restricted medications for Pharmacy Services Lock-In Program members unless specifically designated to do so by the primary lock-in prescriber. For example, if a member sees a cardiologist, the cardiologist may prescribe a statin for the member, but the cardiologist may not prescribe restricted medications unless they have been designated by the lock-in prescriber as an alternate provider.

A referral to an alternate provider for a Pharmacy Services Lock-In Program member is necessary only when the member needs to obtain a prescription for a restricted medication from a provider other than their lock-in prescriber or lock-in pharmacy.

If the member requires alternate prescribers to prescribe restricted medications, the primary lock-in prescriber is required to complete the Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services form. Referrals for fee-for-service members must be on file with the Pharmacy Services Lock-In Program. Referrals for HMO members must be on file with the Pharmacy Service Lock-In Program and the member's HMO.

Designated alternate prescribers are required to be enrolled in Wisconsin Medicaid.

Claims from Providers Who Are Not Designated Pharmacy Services Lock-In Providers

If the member brings a prescription for a restricted medication from a non-lock-in prescriber to the designated lock-in pharmacy, the pharmacy provider cannot fill the prescription.

If a pharmacy claim for a restricted medication is submitted from a provider who is not the designated lock-in prescriber, alternate prescriber, lock-in pharmacy, or alternate pharmacy, the claim will be denied. If a claim is denied because the prescription is not

from a designated lock-in prescriber, the lock-in pharmacy provider cannot dispense the drug or collect a cash payment from the member because the service is a nonreimbursable service. However, the lock-in pharmacy provider may contact the lock-in prescriber to request a new prescription for the drug, if appropriate.

To determine if a provider is on file with the Pharmacy Services Lock-In Program, the lock-in pharmacy provider may do one of the following:

- Speak to the member.
- Call Acentra.
- Call Provider Services.
- Use the ForwardHealth Portal.

Claims are not reimbursable if the designated lock-in prescriber, alternate lock-in prescriber, lock-in pharmacy, or alternate lock-in pharmacy provider is not on file with the Pharmacy Services Lock-In Program.

For More Information

Providers may call Acentra with questions about the Pharmacy Services Lock-In Program. Pharmacy providers may also refer to the list of restricted medications data table or call Provider Services with questions about the following:

- Drugs that are restricted for Pharmacy Services Lock-In Program members
- A member's enrollment in the Pharmacy Services Lock-In Program
- A member's designated lock-in prescriber or lock-in pharmacy

Topic #273

Providers May Refuse to Provide Services

Providers may refuse to provide services to a BadgerCare Plus or Medicaid member in situations when there is reason to believe that the person presenting the ForwardHealth identification card is misusing or abusing it.

Members who abuse or misuse BadgerCare Plus or Wisconsin Medicaid benefits or their ForwardHealth card may have their benefits terminated or be subject to limitations under the Pharmacy Services Lock-In Program or to criminal prosecution.

Topic #275

Requesting Additional Proof of Identity

Providers may request additional proof of identity from a member if they suspect fraudulent use of a ForwardHealth identification card. If another form of identification is not available, providers can compare a person's signature with the signature on the back of the ForwardHealth identification card if it is signed. (Adult members are encouraged to sign the back of their cards; however, it is not mandatory for members to do so.)

Verifying member identity, as well as enrollment, can help providers detect instances of fraudulent ForwardHealth card use.

Coordination of Benefits

7

Archive Date:07/01/2025

Coordination of Benefits:Other Coverage Information

Topic #4940

After Reporting Discrepancies

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

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

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

Topic #4941

Coverage Discrepancies

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

Topic #609

Insurance Disclosure Program

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

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

Topic #610

Maintaining Accurate and Current Records

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

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

- Members

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

Topic #4942

Reporting Discrepancies

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

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

Providers should not use the Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form to update any information regarding a member's coverage in a state-contracted MCO (managed care organization).

When reporting discrepancies, providers should include photocopies of current insurance cards and any available documentation, such as remittance information and benefit coverage dates or denials.

Commercial Health Insurance

Topic #595

Assignment of Insurance Benefits

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

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

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

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

Topic #844

Claims for Services Denied by Commercial Health Insurance

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

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

Topic #598

Commercial Fee-for-Service

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

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

Topic #601

Definition of Commercial Health Insurance

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

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

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

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

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

Topic #602

Discounted Rates

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

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

Topic #596

Exhausting Commercial Health Insurance Sources

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

Step 1. Determine if the Member Has Commercial Health Insurance

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

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

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

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

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

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

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

Step 3. Identify Assignment of Commercial Health Insurance Benefits

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

The provider should proceed in one of the following ways:

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

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

Step 4. Bill Commercial Health Insurance and Follow Up

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

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

Step 5. Submit Claim to ForwardHealth

If only partial reimbursement is received, if the correct and complete claim is denied by commercial health insurance,

or if commercial health insurance does not respond to the original and follow-up claims, the provider may submit a claim to ForwardHealth using the appropriate other insurance indicator or complete the Explanation of Medical Benefits form, as applicable. Commercial remittance information should not be attached to the claim.

Topic #18497

Explanation of Medical Benefits Form Requirement

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

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

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

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

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

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

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

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

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

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

Topic #263

Members Unable to Obtain Services Under Managed

Care Plan

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

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

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

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

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

Topic #604

Non-Reimbursable Commercial Health Insurance Services

Providers are not reimbursed for the following:

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

Topic #605

Other Insurance Indicators

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

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

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

Code	Description

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

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

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

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

Documentation Requirements

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

Topic #603

Services Not Requiring Commercial Health Insurance Billing

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

- Case management services
- CCS (Comprehensive Community Services)
- Crisis Intervention services
- CRS (Community Recovery Services)
- CSP (Community Support Program) services
- Family planning services

- In-home mental health/substance abuse treatment services for children (HealthCheck "Other Services") rendered by providers at the less than bachelor's degree level, bachelor's degree level, QTT (qualified treatment trainee) level, or certified psychotherapist level
- Personal care services
- PNCC (prenatal care coordination) services
- Preventive pediatric services
- SMV (specialized medical vehicle) services

Topic #769

Services Requiring Commercial Health Insurance Billing

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

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

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

- Ophthalmology services
- Optometrist services

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

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

ForwardHealth has identified services requiring Medicare Advantage billing.

Medicare

Topic #664

Acceptance of Assignment

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

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

Topic #666

Claims Denied for Errors

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

Topic #668

Claims Processed by Commercial Health Insurance That Is Secondary to Medicare

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

Topic #670

Claims That Do Not Require Medicare Billing

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

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

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

Topic #704

Claims That Fail to Cross Over

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

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

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

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

Topic #667

Claims for Services Denied by Medicare

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

Topic #671

Crossover Claims

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

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

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

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

- Automatic crossover claims

- Provider-submitted crossover claims

Automatic Crossover Claims

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

Claims will be forwarded if the following occur:

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

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

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

Provider-Submitted Crossover Claims

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

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

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

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

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

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

- Paper claim form

Topic #672

Definition of Medicare

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

Medicare coverage is divided into four parts:

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

Topic #684

Dual Eligibles

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

Dual eligibles may receive coverage for the following:

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

Topic #669

Exhausting Medicare Coverage

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

Adjustment Request for Crossover Claim

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

Provider-Submitted Crossover Claim

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

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

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

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

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

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

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

Claim for Services Denied by Medicare

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

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

Crossover Claim Previously Reimbursed

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

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

In these situations, the provider should proceed as follows:

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

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

Topic #687

Medicare Advantage

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

ForwardHealth has identified services requiring Medicare Advantage billing.

Paper Crossover Claims

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

Reimbursement Limits

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

Topic #20677

Medicare Cost

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

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

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

Topic #688

Medicare Disclaimer Codes

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

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

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

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

- The service is usually covered by Medicare Part B but not in this circumstance (for example, member's diagnosis).

Documentation Requirements

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

Topic #8457

Medicare Late Fees

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

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

Resubmitting Medicare Crossover Claims with Late Fees

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

Paper Claim Submissions

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

Electronic Claim Submissions

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

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

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

Since ForwardHealth considers the late fee part of the paid amount, providers should add the late fee to the paid amount reported on the Medicare remittance. In the example above, add the late fee of $5 to the paid amount of $75 for a total of $80. The claim should report the Medicare paid amount as $80.

Topic #689

Medicare Provider Enrollment

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

Services for Dual Eligibles

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

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

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

Services for Qualified Medicare Beneficiary-Only Members

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

Topic #690

Medicare Retroactive Eligibility — Member

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

Topic #895

Modifier for Catastrophe/Disaster-Related Crossover Claims

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

Topic #4957

Provider-Submitted Crossover Claims

A provider-submitted crossover claim is a Medicare-allowed claim that a provider directly submits to ForwardHealth when the Medicare claim did not automatically crossover to ForwardHealth.

Electronic Professional Crossover Claims

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

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

Paper Professional Crossover Claims

All paper provider-submitted crossover claims submitted on the 1500 Health Insurance Claim Form ((02/12)) require a provider signature and date in Item Number 31. The words "signature on file" are not acceptable. Provider-submitted crossover claims without a signature or date are denied or are subject to recoupment. The provider signature requirement for paper crossover claims is the same requirement for all other paper 1500 Health Insurance Claims.

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

Topic #692

Qualified Medicare Beneficiary-Only Members

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

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

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

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

Topic #686

Reimbursement for Crossover Claims

Professional Crossover Claims

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

Total payment for a Medicare Part B-covered service (for example, any amount paid by other health insurance sources, any

copay or spenddown amounts paid by the member, and any amount paid by Wisconsin Medicaid) may not exceed the Medicare-allowed amount. Therefore, Medicaid reimbursement for coinsurance or copay of a Medicare Part B-covered service is the lesser of the following:

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

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

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

Outpatient Hospital Crossover Claims

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

Inpatient Hospital Services

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

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

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

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

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

Difference between Medicaid-allowed amount and Medicare-paid amount	$200	($-50)	$250
Medicare coinsurance, copay and deductible	$0	$200	$500
Medicaid payment	$0	$0	$250

Nursing Home Crossover Claims

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

Topic #4977

Rendering Provider on Professional Crossover Claims

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

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

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

Topic #770

Services Requiring Medicare Advantage Billing

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

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

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

ForwardHealth has identified services requiring commercial health insurance billing.

Provider-Based Billing

Topic #660

Purpose of Provider-Based Billing

The purpose of provider-based billing is to reduce costs by ensuring that providers receive maximum reimbursement from other health insurance sources that are primary to BadgerCare Plus or Wisconsin Medicaid. For example, a provider-based billing claim is created when BadgerCare Plus or Wisconsin Medicaid pays a claim and later discovers that other coverage exists or was made retroactive. Since BadgerCare Plus and Wisconsin Medicaid benefits are secondary to those provided by most other health insurance sources, providers are required to seek reimbursement from the primary payer, as stated in Wis. Admin. Code § DHS 106.03(7).

Topic #658

Questions About Provider-Based Billing

For questions about provider-based billing claims that are within the 120-day limit, providers may call the Coordination of Benefits Unit at 608-243-0676. Providers may fax the corresponding Provider-Based Billing Summary to 608-221-4567 at the time of the telephone call.

For questions about provider-based billing claims that are **not** within the 120-day limit, providers may call Provider Services.

Topic #661

Receiving Notification

When a provider-based billing claim is created, the provider will receive the following:

- A notification letter.
- A Provider-Based Billing Summary. The summary lists each claim from which a provider-based billing claim was created. The summary also indicates the corresponding primary payer for each claim and necessary information for providers to review and handle each claim.

If a member has coverage through multiple other health insurance sources, the provider may receive additional provider-based billing summaries and provider-based billing claims for each other health insurance source that is on file.

Accessing Provider-Based Billing Summary Reports

Providers can retrieve provider-based billing summary reports through the Portal by logging in to their secure provider Portal account. Once logged in, providers can click the Provider Based Bills (PBB) link located in the Quick Links box of the Providers area of the Portal to access the Provider Based Billing page. This page has links for the provider to download provider-based summary reports in .csv or .pdf format.

Refer to the Provider-Based Billing Retrieval User Guide for step-by-step instructions on how to access the Provider Based Billing page and download provider-based summary reports.

Note: ForwardHealth also sends the paper provider-based billing summary report to the provider's "mail to" address on file in the Portal.

The provider-based billing process runs monthly on the first full weekend of every month, and files are available once the process is completed.

Topic #659

Responding to ForwardHealth After 120 Days

If a response is not received within 120 days, the amount originally paid by BadgerCare Plus or Wisconsin Medicaid will be withheld from future payments. This is not a final action. To receive payment after the original payment has been withheld, providers are required to submit the required documentation to the appropriate address as indicated in the following tables. For DOS (dates of service) that are within claims submission deadlines, providers should refer to the first table. For DOS that are beyond claims submission deadlines, providers should refer to the second table.

Within Claims Submission Deadlines		
Scenario	**Documentation Requirement**	**Submission Address**
The provider discovers through the EVS (Enrollment Verification System) that ForwardHealth has removed or end-dated the other health insurance coverage from the member's file.	A claim according to normal claims submission procedures (do **not** use the provider-based billing summary).	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784
The provider discovers that the member's other coverage information (that is, enrollment dates) reported by the EVS is invalid.	• A Commercial Other Coverage Discrepancy Report (F-01159 (04/2017)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/2018)) form. • A claim according to normal claims submission procedures after verifying that the member's other coverage information has been updated by using the EVS (do **not** use the provider-based billing summary).	Send the Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form to the address indicated on the form. Send the claim to the following address: ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	• A claim according to normal claims submission procedures (do **not** use the provider-based billing summary). • The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784

	◦ The amount received from the other health insurance source on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	
The other health insurance source denies the provider-based billing claim.	◦ A claim according to normal claims submission procedures (do **not** use the provider-based billing summary). ◦ The appropriate other insurance indicator or Medicare disclaimer code on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784
The commercial health insurance carrier does not respond to an initial **and** follow-up provider-based billing claim.	◦ A claim according to normal claims submission procedures (do **not** use the provider-based billing summary). ◦ The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784

Beyond Claims Submission Deadlines		
Scenario	**Documentation Requirement**	**Submission Address**
The provider discovers through the EVS that ForwardHealth has removed or end-dated the other health insurance coverage from the member's file.	◦ A claim (do **not** use the provider-based billing summary). ◦ A Timely Filing Appeals Request (F-13047 (08/2015)) form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The provider discovers that the member's other coverage information (that is, enrollment dates) reported by the EVS is invalid.	◦ A Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form. ◦ **After** using the EVS to verify that the member's other coverage information has been updated, include both of the following: ▪ A claim (do **not** use the provider-based billing summary.)	Send the Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form to the address indicated on the form. Send the timely filing appeals request to the following address:

	¡ A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The commercial health insurance carrier reimburses or partially reimburses the provider-based billing claim.	ı A claim (do **not** use the provider-based billing summary). ı Indicate the amount received from the commercial health insurance on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. ı A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The other health insurance source denies the provider-based billing claim.	ı A claim. ı The appropriate other insurance indicator or Medicare disclaimer code on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. ı A Timely Filing Appeals Request form according to normal timely filing appeals procedures. ı The Provider-Based Billing Summary. ı Documentation of the denial, including any of the following: ¡ Remittance information from the other health insurance source. ¡ A written statement from the other health insurance source identifying the reason for denial. ¡ A letter from the other health insurance source indicating a policy termination date that proves that the other health insurance source paid the member. ¡ A copy of the insurance card or other documentation from the other health insurance source that indicates that the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage only.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

	▪ The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.	
The commercial health insurance carrier does not respond to an initial and follow-up provider-based billing claim.	▪ A claim (do **not** use the provider-based billing summary). ▪ The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. ▪ A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Topic #662

Responding to ForwardHealth Within 120 Days

Within 120 days of the date on the Provider-Based Billing Summary, the Provider-Based Billing Unit must receive documentation verifying that one of the following occurred:

- The provider discovers through the EVS (Enrollment Verification System) that ForwardHealth has removed or end-dated the other health insurance coverage from the member's file.
- The provider verifies that the member's other coverage information reported by ForwardHealth is invalid.
- The other health insurance source reimbursed or partially reimbursed the provider-based billing claim.
- The other health insurance source denied the provider-based billing claim.
- The other health insurance source failed to respond to an initial **and** follow-up provider-based billing claim.

When responding to ForwardHealth within 120 days, providers are required to submit the required documentation to the appropriate address as indicated in the following table. If the provider's response to ForwardHealth does not include all of the required documentation, the information will be returned to the provider. The provider is required to send the complete information within the original 120-day limit.

Scenario	Documentation Requirement	Submission Address
The provider discovers through the EVS that ForwardHealth has removed or end-dated the other health insurance coverage from the member's file.	▪ The Provider-Based Billing Summary. ▪ Indication that the EVS no longer reports the member's other coverage.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567
The provider discovers that the member's other coverage information (enrollment dates) reported by the EVS is invalid.	▪ The Provider-Based Billing Summary. ▪ One of the following: ▪ The name of the person with whom the provider spoke and the member's correct other coverage information.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567

	◦ A printed page from an enrollment website containing the member's correct other coverage information.	
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	▪ The Provider-Based Billing Summary. ▪ A copy of the remittance information received from the other health insurance source. ▪ The DOS (date of service), other health insurance source, billed amount, and procedure code indicated on the other insurer's remittance information must match the information on the Provider-Based Billing Summary. ▪ A copy of the Explanation of Medical Benefits form, as applicable. Note: In this situation, ForwardHealth will initiate an adjustment if the amount of the other health insurance payment does not exceed the allowed amount (even though an adjustment request should not be submitted). However, providers (except nursing home and hospital providers) may issue a cash refund. Providers who choose this option should include a refund check but should not use the Claim Refund form.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567
The other health insurance source denies the provider-based billing claim.	▪ The Provider-Based Billing Summary. ▪ Documentation of the denial, including any of the following: ◦ Remittance information from the other health insurance source. ◦ A letter from the other health insurance source indicating a policy termination date that precedes the DOS. ◦ Documentation indicating that the other health insurance source paid the member. ◦ A copy of the insurance card or other	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567

	documentation from the other health insurance source that indicates the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage. A copy of the Explanation of Medical Benefits form, as applicable. The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.	
The other health insurance source fails to respond to the initial **and** follow-up provider-based billing claim.	The Provider-Based Billing Summary. Indication that no response was received by the other health insurance source. Indication of the dates that the initial and follow-up provider-based billing claims were submitted to the other health insurance source.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567

Topic #663

Submitting Provider-Based Billing Claims

For each provider-based billing claim, the provider is required to send a claim to the appropriate other health insurance source. The provider should add all information required by the other health insurance source to the claim. The providers should also attach additional documentation (for example, Medicare's remittance information) if required by the other health insurance source.

Reimbursement for Services Provided for Accident Victims

Topic #657

Billing Options

Providers may choose to seek payment from either of the following:

- Civil liabilities (for example, injuries from an automobile accident)
- Worker's compensation

However, as stated in Wis. Admin. Code § DHS 106.03(8), BadgerCare Plus and Wisconsin Medicaid will not reimburse providers if they receive payment from either of these sources.

The provider may choose a different option for each DOS (date of service). For example, the decision to submit one claim to ForwardHealth does not mean that all claims pertaining to the member's accident must be submitted to ForwardHealth.

Topic #829

Points of Consideration

Providers should consider the time and costs involved when choosing whether to submit a claim to ForwardHealth or seek payment from a settlement.

Time

Providers are not required to seek payment from worker's compensation or civil liabilities, rather than seeking reimbursement from BadgerCare Plus or Wisconsin Medicaid, because of the time involved to settle these cases. While some worker's compensation cases and certain civil liability cases may be settled quickly, others may take several years before settlement is reached.

Costs

Providers may receive more than the allowed amount from the settlement; however, in some cases the settlement may not be enough to cover all costs involved.

Topic #826

Seeking Payment From Settlement

After choosing to seek payment from a settlement, the provider may **instead** submit the claim to ForwardHealth as long as it is submitted before the claims submission deadline. For example, the provider may instead choose to submit the claim to ForwardHealth because no reimbursement was received from the liability settlement or because a settlement has not yet been reached.

Topic #827

Submitting Claims to ForwardHealth

If the provider chooses to submit a claim to ForwardHealth, they may not seek further payment for that claim in any liability settlement that may follow. Once a claim is submitted to ForwardHealth, the provider may not decide to seek reimbursement for that claim in a liability settlement. Refunding payment and then seeking payment from a settlement may constitute a felony. If a settlement occurs, ForwardHealth retains the sole right to recover medical costs.

Providers are required to indicate an accident-related diagnosis code on claims when services are provided to an accident victim. If the member has other health insurance coverage, the provider is required to exhaust the other health insurance sources before submitting the claim to ForwardHealth.

Resources

8

Archive Date:07/01/2025

Resources:WiCall

Topic #257

Enrollment Inquiries

WiCall is an AVR (Automated Voice Response) system that allows providers with phones direct access to enrollment information.

Information from WiCall will be returned in the following order if applicable to the member's current enrollment:

- Transaction number: A number will be given as a transaction confirmation that providers should keep for their records.
- Benefit enrollment: All benefit plans the member is enrolled in on the DOS (date of service) or within the DOS range selected for the financial payer.
- County code: The member's county code will be provided if available. The county code is a two-digit code between 01 and 72 that represents the county in which member resides. If the enrollment response reflects that the member resides in a designated HPSA (Health Personnel Shortage Area) on the DOS or within the DOS range selected, HPSA information will be given.
- MCO (managed care organization): All information about state-contracted MCO enrollment, including MCO names and telephone numbers, that exists on the DOS or within the DOS range selected will be listed. This information is applicable to Medicaid and BadgerCare Plus members only.
- Hospice: If the member is enrolled in the hospice benefit on the DOS or within the DOS range that the provider selected, the hospice information will be given. This information is applicable to Medicaid and BadgerCare Plus members only.
- Lock-in: Information about the Pharmacy Services Lock-In Program that exists on the DOS or within the DOS range selected will be provided. This information is applicable to Medicaid, BadgerCare Plus, and SeniorCare members only.
- Medicare: All information about Medicare coverage, including type of coverage and Medicare member ID, if available, that exists on the DOS or within the DOS range selected will be listed.
- Commercial health insurance coverage: All information about commercial coverage, including carrier names and telephone numbers, if available, that exists on the DOS or within the DOS range selected will be listed.
- Transaction completed: After the member's enrollment information has been given using the financial payer that was selected, providers will be given the following options to:
    - Hear the information again.
    - Request enrollment information for the same member using a different financial payer.
    - Hear another member's enrollment information using the same financial payer.
    - Hear another member's enrollment information using a different financial payer.
    - Return to the main menu.

WiCall is available 24 hours a day, seven days a week. If for some reason the system is unavailable, providers may call Provider Services.

Transaction Number

The AVR system issues a transaction number every time a provider verifies enrollment, even when an individual is **not** enrolled in BadgerCare Plus or Wisconsin Medicaid. The provider should retain this transaction number. It is proof that an inquiry was made about the member's enrollment. If a provider thinks a claim was denied in error, the provider can reference the transaction number to ForwardHealth to confirm the enrollment response that was actually given.

Topic #6257

Entering Letters into WiCall

For some WiCall inquries, health care providers are required to enter their taxonomy code with their NPI (National Provider Identifier). Because taxonomy codes are a combination of numbers and letters, telephone key pad combinations, shown in the table below, allow providers to successfully enter taxonomy code letters for WiCall functions (for example, press *21 to enter an A, press *72 to enter an R).

Letter	Key Combination	Letter	Key Combination
A	*21	N	*62
B	*22	O	*63
C	*23	P	*71
D	*31	Q	*11
E	*32	R	*72
F	*33	S	*73
G	*41	T	*81
H	*42	U	*82
I	*43	V	*83
J	*51	W	*91
K	*52	X	*92
L	*53	Y	*93
M	*61	Z	*12

Additionally, providers may select option 9 and press # for an automated voice explanation of how to enter letters in WiCall.

Topic #466

Information Available Via WiCall

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

- Claim status
- Enrollment verification
- PA (prior authorization) status
- Provider CheckWrite information

Note: ForwardHealth releases CheckWrite information to WiCall no sooner than on the first state business day following the financial cycle.

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

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

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

Claim Status

Providers may check the status of a specific claim by selecting the applicable financial payer program, (for example, Wisconsin Medicaid, WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)) and entering their provider ID, member identification number, DOS (date of service), and the amount billed.

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

Enrollment Verification

Providers may request enrollment status for any date of eligibility the member has on file by entering their provider ID and the member ID. If the member ID is unknown, providers may enter the member's date of birth and SSN (Social Security number). Additionally, the provider is prompted to enter the From DOS and the To DOS for the inquiry. The From DOS is the earliest date the provider requires enrollment information and the To DOS must be within 365 days of the "From" DOS.

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

PA Status

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

Information on past PAs is retained indefinitely. Paper PAs require a maximum of 20 working days from receipt to be processed and incorporated into WiCall's PA status information.

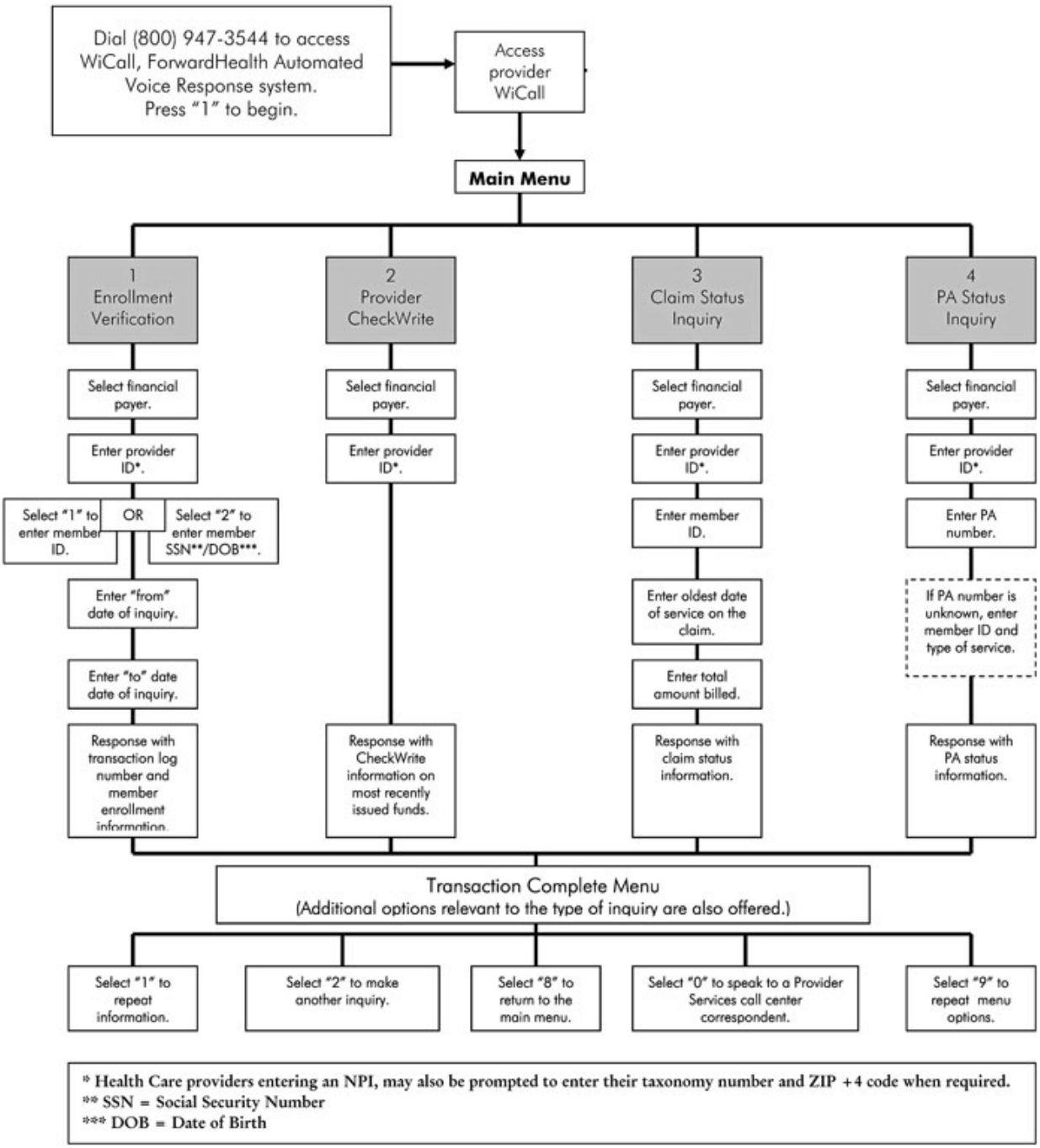
Note: PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Topic #765

Quick Reference Guide

The WiCall AVR (Automated Voice Response) Quick Reference Guide displays the information available for WiCall inquiries.

Automated Voice Response Quick Reference Guide



* Health Care providers entering an NPI, may also be prompted to enter their taxonomy number and ZIP +4 code when required.
** SSN = Social Security Number
*** DOB = Date of Birth

Electronic Data Interchange

Topic #459

Companion Guides and NCPDP Version D.0 Payer Sheet

Companion guides and the NCPDP (National Council for Prescription Drug Programs) version D.0 payer sheet are available for download on the ForwardHealth Portal.

Purpose of Companion Guides

ForwardHealth companion guides and payer sheet provide trading partners with useful technical information on ForwardHealth's standards for nationally recognized electronic transactions.

The information in companion guides and payer sheet applies to BadgerCare Plus, Medicaid, SeniorCare, HDAP (Wisconsin HIV Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program). Companion guides and payer sheet are intended for information technology and systems staff who code billing systems or software.

The companion guides and payer sheet complement the federal HIPAA (Health Insurance Portability and Accountability Act of 1996) implementation guides and highlight information that trading partners need to successfully exchange electronic transactions with ForwardHealth, including general topics such as the following:

- Methods of exchanging electronic information (for example, exchange interfaces, transaction administration, and data preparation)
- Instructions for constructing the technical component of submitting or receiving electronic transactions (for example, claims, RA (Remittance Advice), and enrollment inquiries)

Companion guides and payer sheet do **not** include program requirements, but help those who create the electronic formats for electronic data exchange.

Companion guides and payer sheet cover the following specific subjects:

- Getting started (for example, identification information, testing, and exchange preparation)
- Transaction administration (for example, tracking claims submissions, contacting the EDI (Electronic Data Interchange) Helpdesk)
- Transaction formats

Revisions to Companion Guides and Payer Sheet

Companion guides and payer sheet may be updated as a result of changes to federal requirements. When this occurs, ForwardHealth will do the following:

- Post the revised companion guides and payer sheet on the ForwardHealth Portal.
- Post a message on the banner page of the RA.
- Send an email to trading partners.

Trading partners are encouraged to periodically check for revised companion guides and payer sheet on the Portal. If trading partners do not follow the revisions identified in the companion guides or payer sheet, transactions may not process successfully

(for example, claims may deny or process incorrectly).

A change summary located at the end of the revised companion guide lists the changes that have been made. The date on the companion guide reflects the date the revised companion guide was posted to the Portal. In addition, the version number located in the footer of the first page is changed with each revision.

Revisions to the payer sheet are listed in Appendix A. The date on the payer sheet reflects the date the revised payer sheet was posted to the Portal.

Topic #460

Data Exchange Methods

The following data exchange methods are supported by the EDI (Electronic Data Interchange) Helpdesk:

- Remote access server dial-up, using a personal computer with a modem, browser, and encryption software
- Secure web, using an internet service provider and a personal computer with a modem, browser, and encryption software
- Real-time, by which trading partners exchange the NCPDP (National Council for Prescription Drug Programs) D.0, 270/271 (270/271 Eligibility & Benefit Inquiry and Response), 276/277 (276/277 Health Care Claim Status Request and Response), or 278 (278 Health Care Services Review — Request for Review and Response) transactions via an approved clearinghouse

The EDI Helpdesk supports the exchange of the transactions for BadgerCare Plus, Medicaid, SeniorCare, HDAP (Wisconsin HIV Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program).

Topic #461

Electronic Data Interchange Helpdesk

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

Providers with policy questions should call Provider Services.

Topic #462

Electronic Transactions

HIPAA (Health Insurance Portability and Accountability Act of 1996) ASC (Accredited Standards Committee) X12 Version 5010 Companion Guides and the NCPDP (National Council for Prescription Drug Programs) Version D.0 Payer Sheet are available for download on the HIPAA Version 5010 Companion Guides and NCPDP Version D.0 Payer Sheet page of the ForwardHealth Portal.

Trading partners may submit claims and adjustment requests, inquire about member enrollment, claim status, and ForwardHealth payment advice by exchanging electronic transactions.

Through the EDI (Electronic Data Interchange) Helpdesk, trading partners may exchange the following electronic transactions:

- 270/271 (270/271 Eligibility & Benefit Inquiry and Response): The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.
- 276/277 (276/277 Health Care Claim Status Request and Response): The 276 is the electronic transaction for checking claim status. The 277 is received in response.
- 278 (278 Health Care Services Review — Request for Review and Response): The electronic transaction for health care service PA (prior authorization) requests.
- 835 (835 Health Care Claim Payment/Advice): The electronic transaction for receiving remittance information.
- 837 (837 Health Care Claim): The electronic transaction for submitting claims and adjustment requests.
- 999 (999 Acknowledgment for Health Care Insurance): The electronic transaction for reporting whether a transaction is accepted or rejected.
- TA1 interChange Acknowledgment: The electronic transaction for reporting a transaction that is rejected for interChange-level errors.
- NCPDP D.0 Telecommunication Standard for Retail Pharmacy claims: The real-time POS (Point-of-Sale) electronic transaction for submitting pharmacy claims.

Topic #463

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. PES (Provider Electronic Solutions) software allows providers to submit 837 (837 Health Care Claim) transactions and download the 999 (999 Acknowledgment for Health Care Insurance) and the 835 (835 Health Care Claim Payment/Advice) transactions. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Topic #464

Trading Partner Profile

A Trading Partner Profile must be completed and signed for each billing provider number that will be used to exchange electronic transactions.

In addition, billing providers who do not use a third party to exchange electronic transactions, billing services, and clearinghouses are required to complete a Trading Partner Profile.

To determine whether a Trading Partner Profile is required, providers should refer to the following:

- Billing providers who do not use a third party to exchange electronic transactions, including providers who use the PES (Provider Electronic Solutions) software, are required to complete the Trading Partner Profile.
- Billing providers who use a third party (billing services and clearinghouses) to exchange electronic transactions are required to submit a Trading Partner Profile.
- Billing services and clearinghouses, including those that use PES software, that are authorized by providers to exchange electronic transactions on a provider's behalf, are required to submit a Trading Partner Profile.

Providers who change billing services and clearinghouses or become a trading partner should keep their information updated by contacting the EDI (Electronic Data Interchange) Helpdesk.

Topic #465

Trading Partners

ForwardHealth exchanges nationally recognized electronic transactions with trading partners. A trading partner is defined as a covered entity that exchanges electronic health care transactions. The following covered entities are considered trading partners:

- Providers who exchange electronic transactions directly with ForwardHealth
- Billing services and clearinghouses that exchange electronic transactions directly with ForwardHealth on behalf of a billing provider

Enrollment Verification

Topic #256

270/271 Transactions

The 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response) transactions allow for batch enrollment verification, including information for the current benefit month or for any date of eligibility the member has on file, through a secure internet connection. The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.

For those providers who are federally required to have an NPI (National Provider Identifier), an NPI is required on the 270/271 transactions. The NPI indicated on the 270 is verified to ensure it is associated with a valid enrollment on file with ForwardHealth. The 271 response will report the NPI that was indicated on the 270.

For those providers exempt from NPI, a provider ID is required on the 270/271 transactions. The provider ID indicated on the 270 is verified to ensure it is associated with a valid enrollment on file with ForwardHealth. The 271 response will report the provider ID that was indicated on the 270.

Topic #469

An Overview

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

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

Topic #259

Commercial Enrollment Verification Vendors

ForwardHealth has agreements with several commercial enrollment verification vendors to offer enrollment verification technology to ForwardHealth providers. Commercial enrollment verification vendors have up-to-date access to the ForwardHealth enrollment files to ensure that providers have access to the most current enrollment information. Providers may access Wisconsin's EVS (Enrollment Verification System) to verify member enrollment through one or more of the following methods available from commercial enrollment verification vendors:

- Magnetic stripe card readers
- Personal computer software
- Internet

Vendors sell magnetic stripe card readers, personal computer software, internet access, and other services. They also provide ongoing maintenance, operations, and upgrades of their systems. Providers are responsible for the costs of using these enrollment verification methods.

Note: Providers are **not** required to purchase services from a commercial enrollment verification vendor. For more information on other ways to verify member enrollment or for questions about ForwardHealth identification cards, contact Provider Services.

The real-time enrollment verification methods allow providers to print a paper copy of the member's enrollment information, including a transaction number, for their records. Providers should retain this number or the printout as proof that an inquiry was made.

Magnetic Stripe Card Readers

The magnetic stripe card readers resemble credit card readers. Some ForwardHealth identification cards have a magnetic stripe and signature panel on the back, and a unique, 16-digit card number on the front. The 16-digit card number is valid only for use with a magnetic card reader.

Providers receive current member enrollment information after passing the ForwardHealth card through the reader or entering the member identification number or card number into a keypad and entering the DOS (date of service) about which they are inquiring.

Personal Computer Software

Personal computer software can be integrated into a provider's current computer system by using a modem and can access the same information as the magnetic stripe card readers.

Internet Access

Some enrollment verification vendors provide real-time access to enrollment from the EVS through the internet.

Topic #4903

Copay Information

No Copay

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

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

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

Copay

If a member is enrolled in BadgerCare Plus, Wisconsin Medicaid, or SeniorCare and is required to pay a copay, providers will receive the following response to an enrollment query from all methods of enrollment verification:

- The name of the benefit plan
- The member's enrollment dates

Non-Emergent Copay

If a member is enrolled in BadgerCare Plus and is eligible for the $8 non-emergent copay, providers will receive the following response to an enrollment query from all methods of enrollment verification:

- The name of the benefit plan
- The member's enrollment dates
- The message, Member Eligible for Non-Emergent Copay or Eligible for Non-Emergent Copay

The messages Member Eligible for Non-Emergent Copay and Eligible for Non-Emergent Copay indicate that a member is a BadgerCare Plus childless adult, and they are eligible for the copay if they do not meet the prudent layperson standard and seek and receive additional post-stabilization care in the emergency department after being informed of the $8 copay and availability of alternative providers with lesser or no cost share.

Topic #264

Enrollment Verification System

Member enrollment issues are the primary reason claims are denied. To reduce claim denials, providers should **always** verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Providers may want to verify the member's enrollment a second time before submitting a claim to find out whether the member's enrollment information has changed since the appointment.

Providers can access Wisconsin's EVS (Enrollment Verification System) to receive the most current enrollment information through the following methods:

- ForwardHealth Portal
- WiCall, Wisconsin's AVR (Automated Voice Response) system
- Commercial enrollment verification vendors
- 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Response) transactions
- Provider Services

Providers cannot charge a member, or authorized person acting on behalf of the member, for verifying their enrollment.

The EVS does not indicate other government programs that are secondary to Wisconsin Medicaid.

Topic #4901

Enrollment Verification on the Portal

The secure ForwardHealth Portal offers real-time member enrollment verification for all ForwardHealth programs. Providers will be able to use this tool to determine:

- The benefit plan(s) in which the member is enrolled.
- If the member is enrolled in a state-contracted managed care program (for Medicaid and BadgerCare Plus members).

- If the member has any other coverage, such as Medicare or commercial health insurance.
- If the member is exempted from copays (BadgerCare Plus and Medicaid members only).

To access enrollment verification via the ForwardHealth Portal, providers will need to do the following:

- Go to the ForwardHealth Portal.
- Establish a provider account.
- Log into the secure Portal.
- Click on the menu item for enrollment verification.

Providers will receive a unique transaction number for each enrollment verification inquiry. Providers may access a history of their enrollment inquiries using the Portal, which will list the date the inquiry was made and the enrollment information that was given on the date that the inquiry was made. For a more permanent record of inquiries, providers are advised to use the print screen function to save a paper copy of enrollment verification inquiries for their records or document the transaction number at the beginning of the response, for tracking or research purposes. This feature allows providers to access enrollment verification history when researching claim denials due to enrollment issues.

The Provider Portal is available 24 hours a day, seven days a week.

Topic #4900

Entering Dates of Service

Enrollment information is provided based on a From DOS (date of service) and a To DOS that the provider enters when making the enrollment inquiry. For enrollment inquires, a From DOS is the earliest date for which the provider is requesting enrollment information and the To DOS is the latest date for which the provider is requesting enrollment information.

Providers should use the following guidelines for entering DOS when verifying enrollment for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, or WCDP (Wisconsin Chronic Disease Program) members:

- The From DOS is the earliest date the provider requires enrollment information.
- The To DOS must be within 365 days of the From DOS.
- If the date of the request is prior to the 20th of the current month, then providers may enter a From DOS and To DOS up to the end of the current calendar month.
- If the date of the request is on or after the 20th of the current month, then providers may enter a From DOS and To DOS up to the end of the following calendar month.

For example, if the date of the request was November 15, 2008, the provider could request dates up to and including November 30, 2008. If the date of the request was November 25, 2008, the provider could request dates up to and including December 31, 2008.

Topic #265

Member Forgets ForwardHealth Identification Card

Even if a member does not present a ForwardHealth identification card, a provider can use Wisconsin's EVS (Enrollment Verification System) to verify enrollment; otherwise, the provider may choose not to provide the service(s) until a member brings in a ForwardHealth card or displays a digital ForwardHealth Card on the MyACCESS app.

A provider may use a combination of the member's name, date of birth, ForwardHealth identification number, or SSN (Social Security number) with a 0 at the end to access enrollment information through the EVS.

A provider may call Provider Services with the member's full name and date of birth to obtain the member's enrollment information if the member's identification number or SSN is not known.

Topic #4899

Member Identification Card Does Not Guarantee Enrollment

Most members receive a member identification card, but possession of a program identification card does not guarantee enrollment. Periodically, members may become ineligible for enrollment, only to re-enroll at a later date. Members are told to keep their cards even though they may have gaps in enrollment periods. It is possible that a member will present a card when they are not enrolled; therefore, it is essential that providers verify enrollment before providing services. To reduce claim denials, it is important that providers verify the following information prior to each DOS (date of service) that services are provided:

- If a member is enrolled in any ForwardHealth program, including benefit plan limitations.
- If a member is enrolled in a managed care organization.
- If a member is in primary provider lock-in status.
- If a member has Medicare or other insurance coverage.

Topic #4898

Responses Are Based on Financial Payer

When making an enrollment inquiry through Wisconsin's EVS (Enrollment Verification System), the returned response will provide information on the member's enrollment in benefit plans based on financial payers.

There are three financial payers under ForwardHealth:

- Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and SeniorCare).
- WCDP (Wisconsin Chronic Disease Program).
- WWWP (Wisconsin Well Woman Program).

Within each financial payer are benefit plans. Each member is enrolled under at least one of the three financial payers, and under each financial payer, is enrolled in at least one benefit plan. An individual member may be enrolled under more than one financial payer. (For instance, a member with chronic renal disease may have health care coverage under BadgerCare Plus and the WCDP chronic renal disease program. The member is enrolled under two financial payers, Medicaid and WCDP.) Alternatively, a member may have multiple benefits under a single financial payer. (For example, a member may be covered by Tuberculosis-Related Medicaid and Family Planning Only Services at the same time, both of which are administered by Medicaid.)

Forms

Topic #767

An Overview

ForwardHealth requires providers to use a variety of forms for PA (prior authorization), claims processing, and documenting special circumstances.

Topic #470

Fillable Forms

Most forms may be obtained from the Forms page of the ForwardHealth Portal.

Forms on the Portal are available as fillable PDF files, which can be viewed with Adobe Reader computer software. Providers may also complete and print fillable PDF files using Adobe Reader.

To complete a fillable PDF, follow these steps:

- Select a specific form.
- Save the form to the computer.
- Use the Tab key to move from field to field.

Note: The Portal provides instructions on how to obtain Adobe Reader at no charge from the Adobe website. Adobe Reader only allows providers to view and print completed PDFs. It does not allow users to save completed fillable PDFs to their computer; however, if Adobe Acrobat is purchased, providers may save completed PDFs to their computer. Refer to the Adobe website for more information about fillable PDFs.

Selected forms are also available in fillable Microsoft Word format on the Portal. The fillable Microsoft Word format allows providers to complete and print the form using Microsoft Word. To complete a fillable Microsoft Word form, follow these steps:

- Select a specific form.
- Save the form to the computer.
- Use the Tab key to move from field to field.

Note: Providers may save fillable Microsoft Word documents to their computer by choosing Save As from the File menu, creating a file name, and selecting Save on their desktop.

Topic #766

Telephone or Mail Requests

Providers who do not have internet access or who need forms that are not available on the ForwardHealth Portal may obtain them by doing either of the following:

- Requesting a paper copy of the form by calling Provider Services. Questions about forms may also be directed to Provider

Services.

- Submitting a written request and mailing it to ForwardHealth. Include a return address, the name of the form, and the form number and send the request to the following address:

    ForwardHealth
    Form Reorder
    313 Blettner Blvd
    Madison WI 53784

Updates

Topic #478

Accessing ForwardHealth Communications

ForwardHealth Updates announce changes in policy and coverage, PA (prior authorization) requirements, and claim submission requirements. They communicate new initiatives from the Wisconsin Department of Health Services or new requirements from the federal Centers for Medicare and Medicaid Services and the Wisconsin state legislature.

Updates reflect current policy at the time of publication; this information may change over time and be revised by a subsequent Update. Update information is added to the Online Handbook after the Update is posted, unless otherwise noted.

Providers should refer to the ForwardHealth Online Handbook for current information. The Online Handbook is the source for current ForwardHealth policy and contains provider-specific information for various services and benefits.

Topic #4458

Electronic Notifications from ForwardHealth

ForwardHealth sends electronic messaging using both email subscription and secure Portal messaging to notify providers of newly released ForwardHealth Updates. ForwardHealth also uses electronic messaging to communicate training opportunities and other timely information.

Secure Portal Messages

Providers who have established a secure ForwardHealth Portal account automatically receive messages from ForwardHealth in their secure Portal Messages inbox.

E-mail Subscription Messages

Providers and other interested parties may register to receive e-mail subscription notifications. When registering for email subscription, providers and other interested parties are able to select, by program (for example, Wisconsin Medicaid, BadgerCare Plus, HDAP (Wisconsin HIV Drug Assistance Program), or WCDP (Wisconsin Chronic Disease Program)), provider type (for example, physician, hospital, DME (durable medical equipment) vendor), and/or specific area of interest, (Trading Partner and ICD-10 (International Classification of Diseases, 10th Revision) Project Information) to designate what information they would like to receive. Any number of staff or other interested parties from an organization may sign up for an email subscription and may select multiple subscription options.

Registering for Email Subscription

Users may sign up for an email subscription by following these steps:

1. Click the Register for Email Subscription link on the ForwardHealth Portal home page.
2. The Subscriptions page will be displayed. In the Email field in the New Subscriber section, enter the email address to which messages should be sent.
3. Enter the email address again in the Confirm Email field.

4. Click Register. A message will be displayed at the top of the Subscriptions page indicating the registration was successful. If there are any problems with the registration, an error message will be displayed instead.
5. Once registration is complete, click the program for which you want to receive messages in the Available Subscriptions section of the Subscriptions page. The selected program will expand and a list of service areas will be displayed.
6. Select the service area(s) for which you want to receive messages. Click Select All if you want to receive messages for all service areas.
7. When service area selection is complete, click Save at the bottom of the page.

The selected subscriptions will load and a confirmation message will appear at the top of the page.

Topic #4460

Full Text Publications Available

Providers without internet access may call Provider Services to request that a paper copy of a ForwardHealth Update be mailed to them. To expedite the call, correspondents will ask providers for the Update number. Providers should allow seven to 10 business days for delivery.

Contact Information

Topic #476

Member Services

Providers should refer ForwardHealth members with questions to Member Services. The telephone number for Member Services is for member use only.

Topic #473

Professional Field Representatives

Professional field representatives, also known as field representatives, are available to assist providers with complex billing and claims processing questions. Field representatives are located throughout the state to offer detailed assistance to all ForwardHealth providers and all ForwardHealth programs.

The field representatives are assigned to specific regions of the state. Most professional field representatives can address inquiries for all provider types. However, certain dedicated professional field representatives are assigned to the following:

- Adult long-term care
- Dental providers
- Milwaukee County
- PNCC (Prenatal care coordination) and CCC (child care coordination)
- WWWP (Wisconsin Well Woman Program)

Provider Education

The field representatives' primary focus is provider education. They provide information on ForwardHealth programs and topics in the following ways:

- Conducting provider training sessions throughout the state
- Providing training and information for newly enrolled providers and/or new staff
- Participating in professional association meetings

Providers may also contact the field representatives if there is a specific topic, or topics, on which they would like to have an individualized training session. This could include topics such as use of the ForwardHealth Portal (information about claims, enrollment verification, and PA (prior authorization) requests on the Portal). Refer to the Providers Trainings page for the latest information on training opportunities.

Additional Inquiries

Providers are encouraged to initially obtain information through the Portal, WiCall, and Provider Services. If these attempts are not successful, field representatives may be contacted for the following types of inquiries:

- Claims, including discrepancies regarding enrollment verification and claim processing
- PES (Provider Electronic Solutions) claims submission software
- Claims processing problems that have not been resolved through other channels (for example, phone or written

correspondence)
- Referrals by a Provider Services phone correspondent
- Complex issues that require extensive explanation

At times, professional field representatives work outside their offices to provide on-site service; therefore, providers should be prepared to leave a complete message when contacting field representatives, including all pertinent information related to the inquiry. Member inquiries should not be directed to field representatives. Providers should refer members to Member Services.

If contacting a field representative by email, providers should ensure that no individually identifiable health information, known as PHI (protected health information), is included in the message. Discuss the appropriate method of sending emails with your assigned field representative to ensure secure transmission of information.

Providers or their representatives should have the following information ready when they contact their professional field representative:

- Name or alternate contact
- County and city where services are provided
- Name of facility or provider whom they are representing
- NPI (National Provider Identifier) or provider number
- Phone number, including area code
- A concise statement outlining concern
- Days and times when available

For questions about a specific claim, providers should also include the following information:

- Claim number
- DOS (date of service)

Topic #474

Provider Services

Providers should call Provider Services to answer enrollment, policy, and billing questions. Members should call Member Services for information. Members should **not** be referred to Provider Services.

The Provider Services Call Center provides service-specific assistance to Medicaid, BadgerCare Plus, WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program) providers.

Ways Provider Services Can Help

The Provider Services Call Center is organized to include program-specific and service-specific assistance to providers. The Provider Services Call Center supplements the ForwardHealth Portal and WiCall by providing information on the following:

- Billing and claim submission
- Provider enrollment
- Member enrollment
- COB (coordination of benefits) (for example, verifying a member's other health insurance coverage)
- Assistance with completing forms
- Assistance with remittance information and claim denials
- Policy clarification
- PA (prior authorization) status

- Claim status
- Verifying covered services

Information to Have Ready

When contacting or transferring from WiCall to the call center, callers will be prompted to enter their NPI (National Provider Identifier) or provider ID. Additionally, to facilitate service, providers are recommended to have all pertinent information related to their inquiry on hand when contacting the call center, including:

- Provider name and NPI or provider ID
- Member name and ID
- Claim ICN (internal control number)
- PA number
- DOS (date of service)
- Amount billed
- RA (Remittance Advice)
- Procedure code of the service in question
- Reference to any provider publications that address the inquiry

Call Center Representatives

The ForwardHealth call center representatives are organized to respond to phone calls from providers. Representatives offer assistance and answer inquiries specific to the program (for example, Medicaid, WCDP, or WWWP) or to the service area (for example, pharmacy services, hospital services) in which they are designated.

In addition to trained call center representatives, Provider Services employs an automated tool for assisting callers. The virtual agent is available 24 hours a day, seven days a week to answer questions that do not require a call center representative, such as inquiries related to:

- Claim status
- PA status
- Provider payment status
- Member enrollment verification

Walk-in Appointments

Walk-in appointments offer face-to-face assistance for providers at the Provider Services office. Providers must schedule an appointment in advance by contacting Provider Services at 800-947-9627. Appointments for in-person provider assistance are available Monday through Friday, 7:30 a.m. – 4 p.m. (Central time), except for state-observed holidays. Providers without an appointment may not receive in-person assistance and may have to schedule an appointment for a later date.

Written Inquiries

Providers may contact Provider Services through the Portal by selecting the Contact Us link. Provider Services will respond to the inquiry by the preferred method of response indicated within five business days. All information is transmitted via a secure connection to protect personal health information.

Providers may submit written inquiries to ForwardHealth by mail using the Written Correspondence Inquiry (F-01170 (07/2012)) form. The Written Correspondence Inquiry form may be photocopied or downloaded via a link from the Portal. Written correspondence should be sent to the following address:

ForwardHealth
Provider Services Written Correspondence
313 Blettner Blvd
Madison WI 53784

Providers are encouraged to use the other resources before mailing a written request to ForwardHealth. Provider Services will respond to written inquiries in writing unless otherwise specified.

Topic #4456

Resources Reference Guide

The Provider Services and Resources Reference Guide lists services and resources available to providers and members with contact information and hours of availability.

ForwardHealth Portal	**www.forwardhealth.wi.gov/**	**24 hours a day, seven days a week**
Public and secure access to ForwardHealth information with direct link to contact Provider Services for up-to-date access to ForwardHealth programs information, including publications, fee schedules, and forms.		
WiCall Automated Voice Response System	**800-947-3544**	**24 hours a day, seven days a week**
WiCall, the ForwardHealth AVR (Automated Voice Response) system, provides responses to the following inquiries: - Checkwrite - Claim status - PA (prior authorization) - Member enrollment		
ForwardHealth Provider Services Call Center	**800-947-9627**	**Call center representatives: Monday – Friday, 7 a.m. – 6 p.m. (Central time)* Virtual agent: 24 hours a day, seven days a week**
To assist providers in the following programs: - BadgerCare Plus - Medicaid - SeniorCare - Family Care - Family Care Partnership - IRIS (Include, Respect, I Self-Direct) - PACE (Program of All-Inclusive Care for the Elderly) - HDAP (Wisconsin HIV Drug Assistance Program) - WCDP (Wisconsin Chronic Disease Program) - Wisconsin Medicaid and BadgerCare Plus Managed Care Programs - Wisconsin Well Woman Medicaid		

- WWWP (Wisconsin Well Woman Program)

ForwardHealth Portal Helpdesk	**866-908-1363**	**Monday – Friday, 8:30 a.m. – 4:30 p.m. (Central time)***
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal accounts, registrations, passwords, and submissions through the Portal.		
Electronic Data Interchange Helpdesk	**866-416-4979**	**Monday – Friday, 8:30 a.m. – 4:30 p.m. (Central time)***
For providers, including trading partners, billing services, and clearinghouses with technical questions about the following: - Electronic transactions - Companion documents - PES (Provider Electronic Solutions) software		
Managed Care Provider Appeals	**800-760-0001, Option 1**	**Monday – Friday, 7 a.m. – 6 p.m. (Central time)***
To assist BadgerCare Plus/Medicaid SSI (Supplemental Security Income) HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) providers with questions regarding their appeal status and other general managed care provider appeal information.		
Managed Care Ombudsman Program	**800-760-0001**	**Monday – Friday, 7 a.m. – 6 p.m. (Central time)***
To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.		
Member Services	**800-362-3002**	**Monday – Friday, 8 a.m. – 6 p.m. (Central time)***
To assist ForwardHealth members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		
Wisconsin HIV Drug Assistance Program	**800-991-5532**	**Monday – Friday, 8 a.m. – 4:30 p.m. (Central time)***
To assist HDAP providers and members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		

*With the exception of state-observed holidays.

Portal

Topic #4743

Acute and Primary Managed Care Portal

Information and Functions Through the Portal

The acute and primary managed care area of the ForwardHealth Portal allows state-contracted HMOs to conduct business with ForwardHealth. The public HMO page offers easy access to key HMO information and web tools. A login is required to access the secure area of the Portal to submit or retrieve account and member information that may be sensitive.

The following information is available through the Portal:

- Listing of all Medicaid-enrolled providers
- Coordination of Benefits Extract/Insurance Carrier Master List information updated quarterly
- Data Warehouse, which is linked from the Portal to Business Objects. The Business Objects function allows for access to MCO (managed care organization) data for long-term care MCOs.
- Electronic messages
- Enrollment verification by entering a member ID or SSN (Social Security number) with date of birth and a From DOS (date of service) and a To DOS range. A transaction number is assigned to track the request.
- Member search function for retrieving member information such as medical status codes and managed care and Medicare information
- Provider search function for retrieving provider information such as the address, phone number, provider ID, taxonomy code (if applicable), and provider type and specialty
- HealthCheck information
- MCO contact information
- Technical contact information (Entries may be added via the Portal.)

Topic #4904

Claims and Adjustments Using the ForwardHealth Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, copy claims, and determine what claims are in pay status on the ForwardHealth Portal. Providers have the ability to search for and view the status of all their finalized claims, regardless of how they were submitted (for example, paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim through DDE (Direct Data Entry) through the secure Portal.

Topic #8524

Conducting Revalidation Via the ForwardHealth Portal

Providers can conduct revalidation online via a secure revalidation area of the ForwardHealth Portal.

Topic #4345

Creating a Provider Account

Each provider needs to designate one individual as an administrator of the ForwardHealth Portal account. This user establishes the administrative account once their PIN (personal identification number) is received. The administrative user is responsible for this provider account and can add accounts for other users (clerks) within their organization and assign security roles to clerks that have been established. To establish an administrative account after receiving a PIN, the administrative user is required to follow these steps:

1. Go to the ForwardHealth Portal.
2. Click the **Providers** button.
3. Click **Logging in for the first time?**.
4. Enter the Login ID and PIN. The Login ID is the provider's NPI (National Provider Identifier) or provider number.
5. Click **Setup Account**.
6. At the Account Setup screen, enter the user's information in the required fields. Enter a backup user's information in the required fields.
7. Read the security agreement and click the checkbox to indicate agreement with its contents.
8. Click **Submit** when complete.

Once in the secure Provider area of the Portal, the provider may conduct business online with ForwardHealth via a secure connection. Providers may also perform the following administrative functions from the Provider area of the Portal:

- Establish accounts and define access levels for clerks
- Add other organizations to the account
- Switch organizations

Refer to the Account User Guide on the User Guides page of the Portal for more detailed instructions on performing these functions.

Topic #16737

Demographic Maintenance Tool

The demographic maintenance tool allows providers to update information online that they are required to keep current with ForwardHealth. To access the demographic maintenance tool, providers need a ForwardHealth Portal account. After logging into their Portal account, providers should select the Demographic Maintenance link located in the Home Page box on the right side of the secure Provider home page.

Note: The Demographic Maintenance link will only display for administrative accounts or for clerk accounts that have been assigned the Demographic Maintenance role. The Account User Guide provides specific information about assigning roles.

The demographic maintenance tool contains general panels which are available to all or most providers as well as specific panels which are only available to certain provider types and specialties. The Demographic Maintenance Tool User Guide provides further information about general and provider-specific panels.

Uploading Supporting Documentation

Providers can upload enrollment-related supporting documentation (for example, licenses, certifications) using the demographic maintenance tool. Documents in the following formats can be uploaded:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg)
- PDF (Portable Document Format) (.pdf)

To avoid delays in processing, ForwardHealth strongly encourages providers to upload their documents.

Submitting Information

After making **all** their changes, providers are required to submit their information in order to save it. After submitting information, providers will receive one of the following messages:

- Your information was **updated** successfully. This message indicates that providers' files were immediately updated with the changed information.
- Your information was **uploaded** successfully. This message indicates that ForwardHealth needs to verify the information before providers' files can be updated. Additionally, an Application Submitted panel will display and indicate next steps.

Verification

ForwardHealth will verify changes within 10 business days of submission. If the changes can be verified, ForwardHealth will update providers' files. In some cases, providers may receive a Change Notification letter indicating what information ForwardHealth updated. Providers should carefully review the Provider File Information Change Summary included with the letter to verify the accuracy of the changes. If any of the changes are inaccurate, providers can correct the information using the demographic maintenance tool. Providers may contact Provider Services if they have questions regarding the letter.

Regardless of whether or not providers are notified that their provider files were updated, changed information is not considered approved until 10 business days after the information was changed. If the changes cannot be verified within 10 business days, ForwardHealth will notify providers by mail that their provider files were not updated, and providers will need to make corrections using the demographic maintenance tool.

Topic #4340

Designating a Trading Partner to Receive 835 Health Care Claim Payment/Advice Transactions

Providers must designate a trading partner to receive their 835 (835 Health Care Claim Payment/Advice) transaction for ForwardHealth interChange.

Providers who wish to submit their 835 designation via the Portal are required to create and establish a provider account to have access to the secure area of the Portal.

To designate a trading partner to receive 835 transactions, providers must first complete the following steps:

1. Access the Portal and log into their secure account by clicking the Provider link/button.
2. Click on the Designate 835 Receiver link on the right-hand side of the secure home page.
3. Enter the identification number of the trading partner that is to receive the 835 in the Trading Partner ID field.
4. Click Save.

Providers who are unable to use the Portal to designate a trading partner to receive 835 transactions may call the EDI (Electronic Data Interchange) Helpdesk or submit a paper (Trading Partner 835 Designation, F-13393 (07/12)) form.

Topic #5088

Enrollment Verification

The secure ForwardHealth Portal offers real time member enrollment verification for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled
- Whether or not the member is enrolled in a state-contracted MCO (managed care organization)
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance
- Whether or not the member is enrolled in the Pharmacy Services Lock-In Program and the member's Lock-In pharmacy, primary care provider, and referral providers (if applicable)

Using the Portal to check enrollment may be more effective than calling WiCall or the EVS (Enrollment Verification System) (although both are available).

Providers are assigned a unique enrollment verification number for each inquiry. Providers can also use the print screen function to print a paper copy of enrollment verification inquiries for their records.

Topic #4338

ForwardHealth Portal

Providers, members, trading partners, managed care programs, and partners have access to public **and** secure information through the ForwardHealth Portal.

The Portal has the following areas:

- Providers (public and secure)
- Trading Partners
- Members
- MCO (managed care organization)
- Partners

The secure Portal allows providers to conduct business and exchange electronic transactions with ForwardHealth. The public Portal contains general information accessible to all users. Members can access general health care program information and apply for benefits online.

Topic #4441

ForwardHealth Portal Helpdesk

Providers and trading partners may call the ForwardHealth Portal Helpdesk with technical questions on Portal functions, including their Portal accounts, registrations, passwords, and submissions through the Portal.

Topic #4451

Inquiries to ForwardHealth Via the Portal

Providers are able to contact Provider Services through the ForwardHealth Portal by clicking the Contact link and entering the

relevant inquiry information, including selecting the preferred method of response (for example, telephone call or email). Provider Services will respond to the inquiry by the preferred method of response indicated within five business days.

Topic #4400

Internet Connection Speed

ForwardHealth recommends providers have an internet connection that will provide an upload speed of at least 768 Kbps and a download speed of at least 128 Kbps in order to efficiently conduct business with ForwardHealth via the Portal.

For PES (Provider Electronic Solutions) users, ForwardHealth recommends an internet connection that will provide a download speed of at least 128 Kbps for downloading PES software and software updates from the Portal.

These download speeds are generally not available through a dial-up connection.

Topic #4351

Logging in to the Provider Area of the Portal

Once an administrative user's or other user's account is set up, they may log in to the Provider area of the ForwardHealth Portal to conduct business. To log in, the user is required to click the Provider link or button, then enter their username and password and click Go in the Login to Secure Site box at the right side of the screen.

If a user has forgotten their username, they can recover their username by choosing from the following options:

- Ask the Portal Helpdesk to do one of the following:
  - Send the Portal account username to the email account on record.
  - Verify the request with the designated account backup.
- Ask the Portal Helpdesk to remove the Portal account's current credentials and create a new account.

Topic #5158

Managed Care Organization Portal Reports

The following reports are generated to MCOs (managed care organizations) through their account on the ForwardHealth MCO Portal:

- Capitation Payment Listing Report
- Cost Share Report (long-term MCOs only)
- Enrollment Reports

MCOs are required to establish a Portal account in order to receive reports from ForwardHealth.

Capitation Payment Listing Report

The Capitation Payment Listing Report provides payee MCOs with a detailed listing of the members for whom they receive capitation payments. ForwardHealth interChange creates adjustment transaction information weekly and regular capitation transaction information monthly. The weekly batch report includes regular and adjustment capitation transactions. MCOs have the option of receiving both the Capitation Payment Listing Report and the 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transactions.

Initial Enrollment Roster Report

The Initial Enrollment Roster Report is generated according to the annual schedules detailing the number of new and continuing members enrolled in the MCO and those disenrolled before the next enrollment month.

Final Enrollment Roster Report

The Final Enrollment Roster Report is generated the last business day of each month and includes members who have had a change in status since the initial report and new members who were enrolled after the Initial Enrollment Roster Report was generated.

Other Reports

Additional reports are available for BadgerCare Plus HMOs, SSI HMOs, and long-term MCOs. Some are available via the Portal and some in the secure FTP (file transfer protocol).

Topic #4744

Members ForwardHealth Portal

Members can access ForwardHealth information by going to the ForwardHealth Portal. Members can search through a directory of providers by entering a zip code, city, or county. Members can also access all member-related ForwardHealth applications and forms. Members can use ACCESS to check availability, apply for benefits, check current benefits, and report any changes.

Topic #4344

Obtaining a Personal Identification Number

To establish an account on the ForwardHealth Portal, providers are required to obtain a PIN (personal identification number). The PIN is a unique, nine-digit number assigned by ForwardHealth interChange for the sole purpose of allowing a provider to establish a Portal account. It is used in conjunction with the provider's login ID. Once the Portal account is established, the provider will be prompted to create a username and password for the account, which will subsequently be used to log in to the Portal.

Note: The PIN used to create the provider's Portal account is not the same PIN used for revalidation. Providers will receive a separate PIN for revalidation.

A provider may need to request more than one PIN if he or she is a provider for more than one program or has more than one type of provider enrollment. A separate PIN will be needed for each provider enrollment. Health care providers will need to supply their NPI (National Provider Identifier) and corresponding taxonomy code when requesting an account. Non-healthcare providers will need to supply their unique provider number.

Providers may request a PIN by following these steps:

1. Go to the Portal.
2. Click the Providers link or button.
3. Click the Request Portal Access link from the Quick Links box on the right side of the screen.
4. At the Request Portal Access screen, enter the following information:
    a. Health care providers are required to enter their NPI and click Search to display a listing of ForwardHealth

enrollments. Select the correct enrollment for the account. The taxonomy code, ZIP+4 code, and financial payer for that enrollment will be automatically populated. Enter the SSN (Social Security number) or TIN (Tax Identification Number).

b. Non-healthcare providers are required to enter their provider number, financial payer, and SSN or TIN. (This option should only be used by non-healthcare providers who are exempt from NPI requirements).

   The financial payer is one of the following:
   - Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and SeniorCare.)
   - SSI (Supplemental Security Income)
   - WCDP (Wisconsin Chronic Disease Program)
   - WWWP (Wisconsin Well Woman Program)

c. Click **Submit**.
d. Once the Portal Access Request is successfully completed, ForwardHealth will send a letter with the provider's PIN to the address on file.

Topic #4459

Online Handbook

The Online Handbook gives providers access to all policy and billing information for Wisconsin Medicaid, BadgerCare Plus, HDAP (Wisconsin HIV Drug Assistance Program), and WCDP (Wisconsin Chronic Disease Program). A secure ForwardHealth Portal account is not required to use the Online Handbook, as it is available to all Portal visitors.

Revisions to Online Handbook information are incorporated after policy changes have been issued in ForwardHealth Updates, typically on the policy effective date. The Online Handbook also links to the Communication Home page, which takes users to ForwardHealth Updates, user guides, and other communication pages.

The Online Handbook is designed to sort information based on user-entered criteria, such as program and provider type. It is organized into sections, chapters, and topics. Sections within each handbook may include the following:

- Claims
- Coordination of Benefits
- Covered and Noncovered Services
- Managed Care
- Member Information
- Prior Authorization
- Provider Enrollment and Ongoing Responsibilities
- Reimbursement
- Resources

Each section consists of separate chapters (for example, claims submission, procedure codes), which contain further detailed information in individual topics.

Search Function

The Online Handbook has a search function that allows providers to search for a specific word, phrase, or topic number within a user type, program, service area, or throughout the entire Online Handbook.

Providers can access the search function by following these steps:

1. Go to the Portal.

2. Click **Online Handbooks** under the Policy and Communication heading.
3. Complete the two drop-down selections at the left to narrow the search by program and service area, if applicable. This is not needed if searching the entire Online Handbook.
4. Enter the word, phrase, or topic number you would like to search.
5. Select **Search within the options selected above** or **Search all handbooks, programs and service areas; or Search by Topic Number.**
6. Click **Search**.

Saving Preferences

Providers can select Save Preferences when performing a search (by service area, section, chapter, topic number) and will receive confirmation that their preferences have been saved. This will save the program (for example, BadgerCare Plus and Medicaid) and service area (for example, Anesthesiologist) combinations that are selected from the drop-down menus. The next time the provider accesses the Online Handbook, they will be taken to their default preferences page. The provider can also click the Preferences Home link, which returns the provider to the saved area of the Online Handbook with their default preferences.

ForwardHealth Publications Archive Area

The Handbook Archives page allows providers to view previous versions of the Online Handbook. Providers can access the archive information area by following these steps:

1. Go to the Portal.
2. Click the **Communication Home** link under the Policy and Communication heading.
3. Click the **Online Handbooks** link on the left sidebar menu.
4. Click on the **ForwardHealth Handbook Archives** link at the bottom of the page.

Topic #5089

Other Business Enhancements Available on the Portal

The secure Provider area of the ForwardHealth Portal enables providers to do the following:

- Verify member enrollment.
- View RAs (Remittance Advice).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice).
- Update and maintain provider file information. Providers have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT (electronic funds transfer).
- Track provider-submitted PA (prior authorization) requests.

Topic #4911

Portal Account Administrators

Portal administrators are responsible for requesting, creating, and managing accounts to access these features for their organization.

There must be one administrator assigned for each Portal account and all users established for that account. The responsibilities of the Portal administrator include:

- Ensuring the security and integrity of all user accounts (clerk administrators and clerks) created and associated with their Portal account.
- Ensuring clerks or clerk administrators are given the appropriate authorizations they need to perform their functions for the provider, trading partner, or MCO (managed care organization).
- Ensuring that clerks or clerk administrator accounts are removed/deleted promptly when the user leaves the organization.
- Ensuring that the transactions submitted are valid and recognized by ForwardHealth.
- Ensuring that all users they establish know and follow security and guidelines as required by HIPAA (Health Insurance Portability Accountability Act of 1996). As Portal administrators establish their Portal account and create accounts for others to access private information, administrators are reminded that all users must comply with HIPAA. The HIPAA privacy and security rules require that the confidentiality, integrity, and availability of PHI (protected health information) are maintained at all times. The HIPAA Privacy Rule provides guidelines governing the disclosure of PHI. The HIPAA Security Rule delineates the security measures to be implemented for the protection of electronic PHI. If Portal administrators have any questions concerning the protection of PHI, visit the Portal for additional information.

Portal administrators have access to all secure functions for their Portal account.

Establish an Administrator Account

All Portal accounts require an administrator account. The administrator is a selected individual who has overall responsibility for management of the account. Therefore, they have complete access to all functions within the specific secure area of their Portal and are permitted to add, remove, and manage other individual roles.

Add Backup Contact Information for Provider Administrator Accounts

Provider administrators must set up a backup contact for their Portal accounts to ensure that requests and changes can be verified as legitimate. Provider administrators will not be able to use the same contact information for both the administrator account and the backup contact.

Topic #4912

Portal Clerk Administrators

A Portal administrator may choose to delegate some of the authority and responsibility for setting up and managing the users within their ForwardHealth Portal account. If so, the Portal administrator may establish a clerk administrator. An administrator or clerk administrator can create, modify, manage, or remove clerks for a Portal account. When a clerk is created, the administrator or clerk administrator must grant permissions to the clerks to ensure they have the appropriate access to the functions they will perform. A clerk administrator can only grant permissions that they themselves have. For example, if an administrator gives a clerk administrator permission only for enrollment verification, then the clerk administrator can only establish clerks with enrollment verification permissions.

Even if a Portal administrator chooses to create a clerk administrator and delegate the ability to add, modify, and remove users from the same account, the Portal administrator is still responsible for ensuring the integrity and security of the Portal account.

Topic #4913

Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their ForwardHealth Portal account. Clerks may be assigned one or many roles (for example, claims, PA (prior authorization), member enrollment verification). Clerks do not have the ability to establish, modify, or remove other accounts.

Once a clerk account is set up, the clerk account does not have to be established again for a separate Portal account. Clerks can easily be assigned a role for different Portal accounts (for example, different ForwardHealth enrollments). To perform work under a different Portal account for which they have been granted authorization, a clerk can use the switch org function and toggle between the Portal accounts to which they have access. Clerks may be granted different authorization in each Portal account (for example, they may do member enrollment verification for one Portal account and HealthCheck inquires for another).

Topic #4740

Public Area of the Provider Portal

The public Provider area of the ForwardHealth Portal offers a variety of important business features and functions that will assist in daily business activities with ForwardHealth programs.

Interactive Maximum Allowable Fee Schedule

Within the Portal, are maximum allowable fee schedules for most services. Providers can search the interactive maximum allowable fee schedule by a single procedure code, multiple codes, a code range, or by a service area to find the maximum allowable fee. Through the interactive fee schedule, providers also can export their search results for a single code, multiple codes, a code range, or by service area. The downloadable fee schedules, which are updated monthly, are downloadable only by service area as TXT (text) or CSV (comma separated value) files.

ForwardHealth Communications

ForwardHealth Updates announce changes in policy and coverage, PA (prior authorization) requirements, and claim submission requirements. They communicate new initiatives from the Wisconsin DHS (Department of Health Services) or new requirements from the federal CMS (Centers for Medicare & Medicaid Services) and the Wisconsin state legislature.

Updates reflect current policy at the time of publication; this information may change over time and be revised by a subsequent Update. Update information is added to the ForwardHealth Online Handbook after the Update is posted, unless otherwise noted.

Providers should refer to the Online Handbook for current information. The Online Handbook is the source for current ForwardHealth policy and contains provider-specific information for various services and benefits.

Trainings

Providers can register for all scheduled trainings and view online trainings via the Trainings page, which contains an up-to-date calendar of all available training. Additionally, providers can view webcasts of select trainings.

Contacting Provider Services

Providers and other Portal users will have an additional option for contacting Provider Services through the Contact link on the Portal. Providers can enter the relevant inquiry information, including selecting the preferred method of response (for example, a phone call or email) the provider wishes to receive back from Provider Services. Provider Services will respond to the inquiry within five business days. Information will be submitted via a secure connection.

Online Enrollment

Providers can speed up the enrollment process for Medicaid by completing a provider enrollment application via the Portal. Providers can then track their application by entering their ATN (application tracking number) given to them on completion of the

application.

Other Resources Available on the Portal

The public Provider area of the Portal also includes the following features:

- A What's New? section for providers that links to the latest information posted to the Provider area of the Portal.
- Home page for the provider. (Providers have administrative control over their Portal homepage and can grant other employees access to specified areas of the Portal, such as claims and PA.)
- Email subscription service for Updates. (Providers can register for email subscription to receive notifications of new provider publications via email. Users are able to select, by program and service area, which publication notifications they would like to receive.)
- A forms library.

Topic #4741

Secure Area of the Provider Portal

Providers can accomplish many processes via the ForwardHealth Portal, including submitting, adjusting, and correcting claims, submitting and amending PA (prior authorization) requests, and verifying enrollment.

Claims and Adjustments Using the Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, and determine what claims are in pay status on the Portal. Providers can search for and view the status of all of their finalized claims, regardless of how they were submitted (for example, paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim via DDE (Direct Data Entry) through the secure Portal.

Submitting PA and Amendment Requests Via the Portal

Nearly all service areas can submit PA requests via the Portal. Providers can do the following:

- Correct errors on PA or amendment requests via the Portal, regardless of how the PA request was originally submitted.
- View all recently submitted and finalized PA and amendment requests.
- Save a partially completed PA request and finish completing it at a later time. (Note: providers are required to submit or re-save a PA request within 30 calendar days of the date the PA request was last saved.)
- View all saved PA requests and select any to continue completing or delete.
- View the latest provider review and decision letters.
- Receive messages about PA and amendment requests that have been adjudicated or returned for provider review.

Electronic Communications

The secure Portal contains a two-way message center where providers can send and receive electronic notifications as well as receive links to ForwardHealth provider publications. Providers will be able to send secure messages to select Wisconsin DHS (Department of Health Services) groups/staff by selecting a recipient from a drop-down menu; options in the drop-down menu will differ based on the provider's security role. All new messages will be displayed on the provider's secure Portal messages inbox.

Providers can sign up to receive notifications about the availability of new ForwardHealth messages through email, text, or both. After signing up, the user will receive a verification email to register their device. Once registered, providers will receive notifications by the requested method(s).

Enrollment Verification

The secure Portal offers real-time member enrollment verification for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled.
- Whether or not the member is enrolled in a state-contracted MCO (managed care organization).
- Whether or not the member has other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans), such as Medicare or commercial health insurance.

Using the Portal to check enrollment may be more efficient than calling the AVR (Automated Voice Response) system or the EVS (Enrollment Verification System) (although both are available).

Providers will be assigned a unique enrollment verification number for each inquiry. Providers can also use the print screen function to print a paper copy of enrollment verification inquiries for their records.

Other Business Enhancements Available on the Portal

The secure Provider area of the Portal enables providers to do the following:

- Verify member enrollment.
- View RAs (Remittance Advices).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice) transaction.
- Update and maintain provider file information; providers will have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT (electronic funds transfer).
- Track provider-submitted PA requests.

Topic #4905

Submitting Prior Authorization and Amendment Requests Via the Portal

Nearly all service areas can submit PA (prior authorization) requests via the ForwardHealth Portal. Providers can do the following:

- Correct errors on PAs or amendment requests via the Portal, regardless of how the PA was originally submitted.
- View all recently submitted and finalized PAs and amendment requests.
- View the latest provider review and decision letters.
- Receive messages about PA and amendment requests that have been adjudicated or returned for provider review.

Topic #4401

System and Browser Requirements

The following table lists the recommended system and browser requirements for using the ForwardHealth Portal. PES (Provider Electronic Solutions) users should note that the Windows-based requirements noted in the table apply; PES cannot be run on Apple-based systems.

Recommended System Requirements	Recommended Browser Requirements
Windows-Based Systems	
Computer with at least a 500Mhz processor, 256 MB of RAM, and 100MB of free disk space	Chrome v. 73 or higher, Edge v. 19 or higher, Firefox v. 38 or higher
Windows XP or higher operating system	
Apple-Based Systems	
Computer running a PowerPC G4 or Intel processor, 512 MB of RAM, and 150MB of free disk space	Chrome v. 73 or higher, Edge v. 19 or higher, Safari v. 14 or higher, Firefox v. 38 or higher
Mac OS X 10.2 or higher operating system	

Topic #4742

Trading Partner Portal

The following information is available on the public Trading Partners area of the ForwardHealth Portal:

- Trading partner testing packets
- Trading partner profile submission
- PES (Provider Electronic Solutions) software and upgrade information
- EDI (Electronic Data Interchange) companion guides

In the secure Trading Partners area of the Portal, trading partners can exchange electronic transactions with ForwardHealth.

Trading partners using PES should be sure to enter the web logon and web password associated with the ForwardHealth Trading Partner ID that will be used on PES transactions. Prior to submitting transactions through PES, trading partners must also make sure their trading partner account is entered as the Default Provider ID on the Switch Organization page of the secure trading partner account on the Portal.

Training Opportunities

Topic #12757

Training Opportunities

The Provider Relations representatives conduct training sessions in a variety of formats on both program-specific and topic-specific subjects. There is no fee for attending/accessing these training sessions.

On-Site Sessions

On-site training sessions are offered at various locations (for example, hotel conference rooms, provider facilities) throughout the state. These training sessions include general all-provider sessions, service-specific and/or topic-specific sessions, and program-specific (such as WCDP (Wisconsin Chronic Disease Program) or the WWWP (Wisconsin Well Woman Program)) sessions.

Registration is required to attend on-site sessions. Online registration is available on the Trainings page of the Providers area of the Portal.

Online (Real-Time, Web-Based) Sessions

Online (real-time, web-based) training sessions are available and are facilitated through HPE MyRoom. MyRoom sessions are offered on many of the same topics as on-site sessions, but online sessions offer the following advantages:

- Participants can attend training at their own computers without leaving the office.
- Sessions are interactive as participants can ask questions during the session.
- If requested or needed, a session can be quickly organized to cover a specific topic for a small group or office.

For some larger training topics (such as ForwardHealth Portal Fundamentals), the training may be divided into individual modules, with each module focused on a particular subject. This allows participants to customize their training experience.

Registration, including an email address, is required to attend Virtual Room sessions, so important session information can be sent to participants prior to the start of the session. Online registration is available on the Trainings page of the Portal.

Recorded Webcasts

Recorded Webcasts are available on a variety of topics, including some of the same topics as on-site and online sessions. Like Virtual Room sessions, some recorded Webcasts on larger training topics may be divided into individual Webcast modules, allowing participants to customize their training experience. Recorded Webcasts allow providers to view the training at their convenience on their own computers.

Registration is not required to view a recorded Webcast. Related training materials are available to download and print from the specific webcast training session page on the Portal.

Notification of Training Opportunities

In addition to information on the Trainings page of the Portal, upcoming training session information is distributed directly through messages to providers who have secure Portal accounts and to providers who have registered for the ForwardHealth email subscription service.

To sign up for a secure Portal account, click the Request Portal Access link in the Quick Links box on the Provider page of the Portal. To sign up for email subscription, click Register for Email Subscription in the Quick Links box on the Provider page of the Portal.

Managed Care

9

Archive Date:07/01/2025

Managed Care:Managed Care Information

Topic #401

BadgerCare Plus HMO Program

An HMO is a system of health care providers that provides a comprehensive range of medical services to a group of enrollees. HMOs receive a fixed, prepaid amount per enrollee from ForwardHealth (called a capitation payment) to provide medically necessary services.

BadgerCare Plus HMOs are responsible for providing or arranging all contracted covered medically necessary services to enrollees. BadgerCare Plus members enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service members; however, HMOs may establish their own requirements regarding PA (prior authorization), claims submission, adjudication procedures, etc., which may differ from fee-for-service policies and procedures. BadgerCare Plus HMO network providers should contact their HMO for more information about its policies and procedures.

Topic #16177

Care4Kids Program Overview

Care4Kids is a health care program for children and youth in out-of-home care in Wisconsin. The Care4Kids program will offer comprehensive, coordinated services that are intended to improve the quality and timeliness of and access to health services for these children.

The Care4Kids program will serve children in out-of-home care placements (other than residential care centers) in Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties. Member participation will be voluntary, and enrollment will be allowed to continue for up to 12 months after the child leaves the out-of-home care system, as long as the child remains Medicaid-eligible and resides within one of the six counties.

Care4Kids is required to provide at least the same benefits as those provided under fee-for-service arrangements.

Program Administration

Children's Hospital of Wisconsin is currently the only integrated health system certified by ForwardHealth to administer the Care4Kids program. Children's Hospital of Wisconsin will be responsible for providing or arranging for the provision of all services covered under Medicaid, with a small number of exceptions. The services not included in the Care4Kids program will be reimbursed as fee-for-service benefits. Children's Hospital of Wisconsin's integrated network of health care providers, which includes specialty and primary care physicians and clinics within the Children's Hospital System as well as providers who are participating in CCHP (Children's Community Health Plan), is intended to provide coordinated care and services to meet the individualized needs of each of the children enrolled across multiple disciplines, including physical, behavioral health, and dental care.

Care4Kids will be responsible for providing or arranging for the provision of all medically necessary services covered by Wisconsin Medicaid to enrollees. Providers are required to be part of the CCHP network to get reimbursed by Care4Kids. Providers interested in being a part of the network should contact CCHP. Out-of-network providers are required to call Care4Kids prior to providing services to a Care4Kids enrollee. In situations where emergency medical services are needed, out-of-network providers are required to contact Care4Kids within 24 hours of providing services.

Member Enrollment Verification

Providers should verify a member's enrollment before providing services to determine if the member is enrolled in Care4Kids. Members enrolled in Care4Kids will present a ForwardHealth member identification card.

Providers verifying enrollment on the ForwardHealth Portal will see Care4Kids under the MC Program heading in the Managed Care Enrollment panel.

For 271 response transactions, Care4Kids enrollment will be identified in the EB segment of the 2110C loop. Identified by MC in the EB01, HM in the EB04, and Care4Kids in the EB05. The MC provider contact information will be reported in the NM1 (name info), N3 (address info), and PER (telephone numbers) segments within the 2120C loop.

The WiCall AVR (automated voice response) system will identify Care4Kids as the state-contracted managed care program in which the member is enrolled.

Contact Information

Providers can contact CCHP at 800-482-8010 for the following:

- To become part of the CCHP network
- For coverage policy and procedure information, including PA (prior authorization) and claim submission guidelines, if they are already a Care4Kids network provider

Topic #405

Managed Care

Managed Care refers to the BadgerCare Plus HMO program, the Medicaid SSI HMO program, and the following MLTC (managed long-term care) programs available: Family Care, Family Care Partnership, and PACE (Program of All-Inclusive Care for the Elderly).

The primary goals of the managed care programs are:

- To improve the quality of member care by providing continuity of care and improved access.
- To reduce the cost of health care through better care management.

Topic #402

Managed Care Contracts

The contract between the Wisconsin DHS (Department of Health Services) and the BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) takes precedence over other ForwardHealth provider publications. Information contained in ForwardHealth publications is used by DHS to resolve disputes regarding covered benefits that cannot be handled internally by HMOs or PIHPs. If there is a conflict, the HMO or PIHP contract prevails. If the contract does not specifically address a situation, Wisconsin Administrative Code ultimately prevails. HMO and PIHP contracts are available on the Acute and Primary Managed Care page (click the HMO Providers link, then the Resources and Help tab) for HMOs and on the Children's Specialty Programs page of the ForwardHealth Portal (click the Children's Specialty Managed Care Plans link, then the Policy tab) for PIHPs.

Topic #403

Managed Long-Term Care Programs

Wisconsin Medicaid has several MLTC (managed long-term care) programs that provide services to individuals who are elderly and/or who have disabilities. These members may be eligible to enroll in voluntary regional managed care programs such as Family Care, PACE (Program of All-Inclusive Care for the Elderly), and the Family Care Partnership Program. Additional information about these MLTC programs may be obtained from the Managed Care Organization area of the ForwardHealth Portal.

Topic #404

SSI HMO Program

Medicaid SSI HMOs provide the same benefits as Medicaid fee-for-service (for example, medical, dental [in certain counties only], mental health/substance abuse, and vision) at no cost to their members through a care management model. Medicaid SSI members and SSI-related Medicaid members may be eligible to enroll in an SSI HMO.

SSI-related Medicaid members receive coverage from Wisconsin Medicaid because of a disability determined by the Disability Determination Bureau.

Member Enrollment

Certain eligible SSI members and SSI-related Medicaid adult members are required to enroll in an SSI HMO. The following groups are excluded from the requirement to enroll in an SSI HMO:

- Members under 19 years of age
- Members of a federally recognized tribe
- Dual eligible members
- MAPP (Medicaid Purchase Plan) eligible members
- Members enrolled in a LTC (long-term care) MCO (managed care organization) or waiver program

Continuity of Care

Special provisions are included in the contract for SSI HMOs for continuity of care for SSI members and SSI-related Medicaid members. These provisions include the following:

- Coverage of services provided by the member's current provider for the first 90 days of enrollment in the SSI program or until the first of the month following completion of an assessment and care plan, whichever comes later. The contracted provider should get a referral from the member's HMO after this.
- Honoring a PA (prior authorization) that is currently approved by ForwardHealth. The PA must be honored for 90 days or until the month following the HMO's completion of the assessment and care plan, whichever comes later.

To assure payment, non-contracted providers should contact the SSI HMO to confirm claim submission and reimbursement processes. If an SSI HMO is not honoring a PA that is currently approved by ForwardHealth, the provider should first contact the HMO. If the provider is not able to resolve their issue with the HMO, the provider should contact ForwardHealth Provider Services.

For new authorizations during the member's first 90 days of enrollment, the provider is required to follow the SSI HMO's PA process. SSI HMOs may use PA guidelines that differ from fee-for-service guidelines; however, these guidelines may not result in less coverage than fee-for-service.

Care Management

SSI HMO health plans employ a care management model to ensure high-quality care to members. The care management model provides each enrollee with the following:

- An initial health assessment
- A comprehensive care plan
- Assistance in choosing providers and identifying a primary care provider
- Assistance in accessing social and community services
- Information about health education programs, treatment options, and follow-up procedures
- Advocates on staff to assist members in choosing providers and accessing needed care

ForwardHealth requires all SSI HMO health plans to have dedicated care managers to assist providers in meeting the medical care needs of members. SSI HMOs, through their care management teams, will serve as single points of contact for providers who need assistance addressing the health care needs of members, especially those who have multiple points of contact within the health care system.

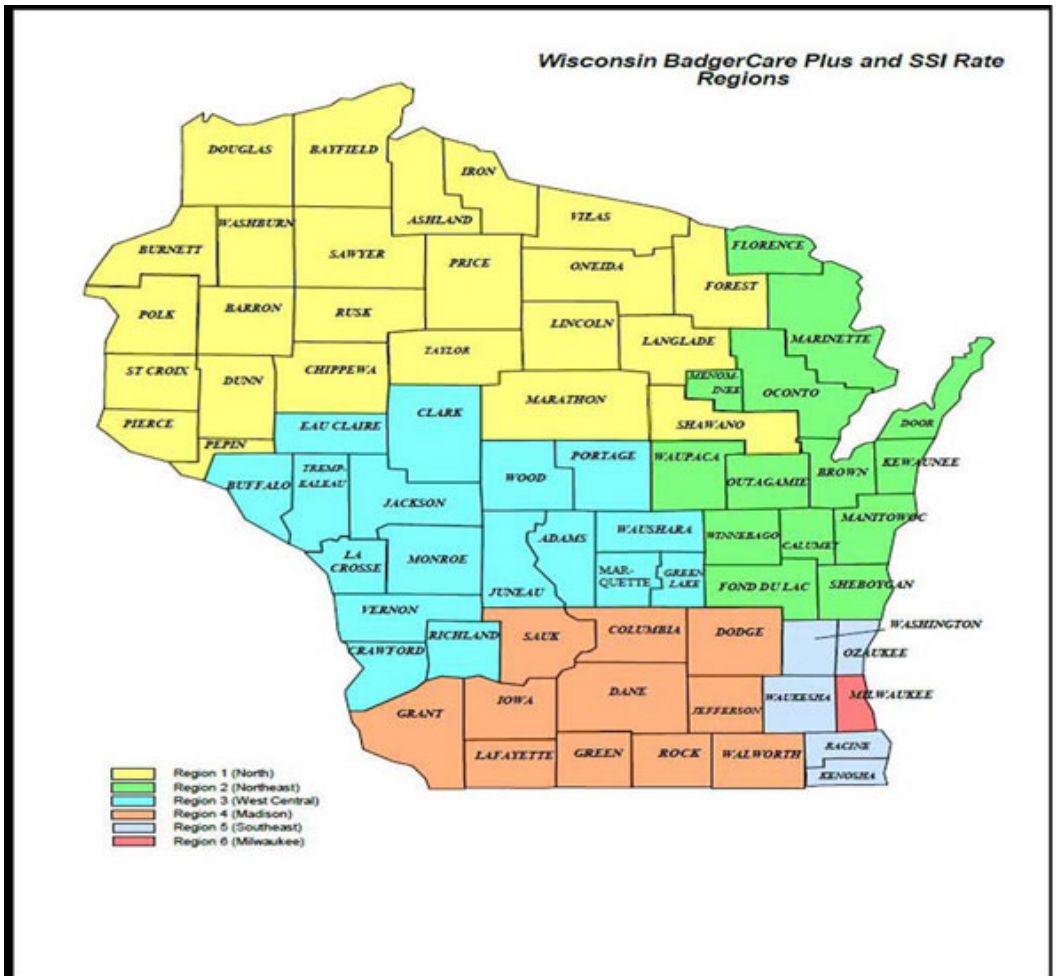
The SSI HMO care management teams will be responsible, when it is deemed appropriate, for notifying primary care providers of members' emergency room visits, hospital discharges, and other major medical events, as well as sharing patient-specific care management plans with appropriate providers to reduce hospital admissions and readmission, to reduce appointment no-shows, and to improve compliance with health care recommendations such as medication regimens.

Topic #20697

SSI Rate Regions

The map below shows the Wisconsin BadgerCare Plus and SSI (Supplemental Security Income) Rate Regions for the SSI HMO Program.

SSI Rate Regions


Wisconsin BadgerCare Plus and SSI Rate Regions
DOUGLAS
BAYFIELD
IRON
ASHLAND
VILAS
WASHBURN
BURNETT
SAWYER
PRICE
ONEIDA
FLORENCE
FOREST
POLK
BARRON
RUSK
LINCOLN
LANGLADE
MARINETTE
ST CROIX
DUNN
CHIPPEWA
TAYLOR
MENOM-INEE
OCONTO
PIERCE
EAU CLAIRE
CLARK
MARATHON
SHAWANO
DOOR
PEPIN
BUFFALO
TREMP-EALEAU
JACKSON
WOOD
PORTAGE
WAUPACA
OUTAGAMIE
BROWN
KEWAUNEE
ADAMS
WAUSHARA
WINNEBAGO
CALUMET
MANITOWOC
LA CROSSE
MONROE
JUNEAU
MAR-QUETTE
GREEN LAKE
FOND DU LAC
SHEBOYGAN
VERNON
RICHLAND
SAUK
COLUMBIA
DODGE
WASHINGTON
CRAWFORD
OZAUKEE
GRANT
IOWA
DANE
JEFFERSON
WAUKESHA
MILWAUKEE
LAFAYETTE
GREEN
ROCK
WALWORTH
RACINE
KENOSHA
Region 1 (North)
Region 2 (Northeast)
Region 3 (West Central)
Region 4 (Madison)
Region 5 (Southeast)
Region 6 (Milwaukee)

Enrollment

Topic #392

Disenrollment and Exemptions

In some situations, a member may be exempt from enrolling in a BadgerCare Plus HMO or Medicaid SSI HMO. Exempted members receive health care under fee-for-service. Exemptions allow members to complete a course of treatment with a provider who is not contracted with BadgerCare Plus HMO or SSI HMOs. For example, in certain circumstances, members seeing a specialist when they are enrolled in an HMO **may** qualify for an exemption if their specialty provider is not in the HMO networks.

The contracts between Wisconsin DHS (Department of Health Services) and the HMOs provide more detail on the exemption and disenrollment requirements.

Topic #393

Enrollee Grievances

Enrollees have the right to file grievances about services or benefits provided by a BadgerCare Plus HMO or Medicaid SSI HMO. Enrollees also have the right to file a grievance when the HMO or SSI HMO refuses to provide a service. All HMOs and SSI HMOs are required to have written policies and procedures in place to handle enrollee grievances. Enrollees should be encouraged to work with their HMO's or SSI HMO's customer service department to resolve problems first.

If enrollees are unable to resolve problems by talking to their HMO or SSI HMO, or if they would prefer to speak with someone outside their HMO or SSI HMO, they should contact the Enrollment Specialist or the Ombudsman Program.

The contracts between Wisconsin DHS (Department of Health Services) and the HMO or SSI HMO describes the responsibilities of the HMO or SSI HMO and the DHS regarding enrollee grievances.

Topic #397

Enrollment Eligibility

BadgerCare Plus HMOs

Members enrolled in BadgerCare Plus are eligible for enrollment in a BadgerCare Plus HMO.

An individual who receives Tuberculosis-Related Medicaid, SeniorCare, or Wisconsin Well Woman Medicaid cannot be enrolled in a BadgerCare Plus HMO.

Information about a member's HMO enrollment status and other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) coverage may be verified by using Wisconsin's EVS (Enrollment Verification System) or the ForwardHealth Portal.

SSI HMOs

Members of the following subprograms are eligible for enrollment in a Medicaid SSI HMO:

- Individuals ages 19 and older who meet the SSI and SSI-related disability criteria
- Dual eligibles for Medicare and Medicaid

Individuals who are living in an institution, nursing home, or participating in a Home and Community-Based Waiver program are not eligible to enroll in an SSI MCO.

Topic #394

Enrollment Periods

BadgerCare Plus HMOs

Eligible enrollees are sent enrollment packets that explain the BadgerCare Plus HMOs and the enrollment process and provide contact information. Once enrolled in a BadgerCare Plus HMO, members may change their HMO assignment within the first 90 days of enrollment in an HMO (whether they chose the HMO or were auto-assigned). If an enrollee no longer meets the criteria, they will be disenrolled from the HMO.

SSI HMOs

Eligible enrollees are sent enrollment packets that explain the Medicaid SSI HMO enrollment process and provide contact information. Once enrolled in an SSI HMO, members may change their HMO assignment within the first 90 days of enrollment in an HMO (whether they chose the HMO or were auto-assigned).

Topic #395

Enrollment Specialist

The Enrollment Specialist provides objective enrollment, education, outreach, and advocacy services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees. The Enrollment Specialist is a knowledgeable single point of contact for enrollees, solely dedicated to managed care issues. The Enrollment Specialist is not affiliated with any health care agency.

The Enrollment Specialist provides the following services to HMO and SSI HMO enrollees:

- Education regarding the correct use of HMO and SSI HMO benefits
- Telephone and face-to-face support
- Assistance with enrollment, disenrollment, and exemption procedures

Topic #398

Member Enrollment

HMOs

BadgerCare Plus HMO enrollment is either mandatory or voluntary based on zip code-defined enrollment areas as follows:

- Mandatory enrollment — Enrollment is mandatory for eligible members who reside in zip code areas served by two or more BadgerCare Plus HMOs. Some members may meet criteria for exemption from BadgerCare Plus HMO enrollment.
- Voluntary enrollment — Enrollment is voluntary for members who reside in zip code areas served by only one BadgerCare

Plus HMO.

Members living in areas where enrollment is mandatory are encouraged to choose their BadgerCare Plus HMO. Automatic assignment to a BadgerCare Plus HMO occurs if the member does not choose a BadgerCare Plus HMO. In general, all members of a member's immediate family eligible for enrollment must choose the same HMO.

Members in voluntary enrollment areas can choose whether or not to enroll in a BadgerCare Plus HMO. There is no automatic assignment for members who live within zip codes where enrollment is voluntary.

SSI HMOs

Medicaid SSI HMO enrollment is either mandatory or voluntary as follows:

- Mandatory enrollment — Most SSI and SSI-related members are required to enroll in an SSI HMO. A member may choose the SSI HMO in which he or she wishes to enroll.
- Voluntary enrollment — Some SSI and SSI-related members may choose to enroll in an SSI HMO on a voluntary basis.

Topic #396

Ombudsman Program

The Ombudsmen, or Ombuds, are resources for enrollees who have questions or concerns about their BadgerCare Plus HMO or Medicaid SSI HMO. Ombuds provide advocacy and assistance to help enrollees understand their rights and responsibilities in the grievance and appeal process.

Ombuds can be contacted at the following address:

BadgerCare Plus HMO/Medicaid SSI HMO Ombudsmen
PO Box 6470
Madison WI 53716-0470

Topic #399

Release of Billing or Medical Information

ForwardHealth supports BadgerCare Plus HMO and Medicaid SSI HMO enrollee rights regarding the confidentiality of health care records. ForwardHealth has specific standards regarding the release of an HMO or SSI HMO enrollee's billing information or medical claim records.

Provider Information

Topic #406

Copays

Providers cannot charge Medicaid SSI HMO enrollees copays for covered services except in cases where the Medicaid SSI HMO does not cover services such as dental, chiropractic, and pharmacy. However, even in these cases, providers are prohibited from collecting copay from members who are exempt from the copay requirement.

When services are provided through fee-for-service or to members enrolled in a BadgerCare Plus HMO, copays will apply, except when the member or the service is exempt from the copay requirement.

Topic #407

Emergencies

Non-network providers may provide services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees in an emergency without authorization or in urgent situations when authorized by the HMO or SSI HMO. The contract between Wisconsin DHS (Department of Health Services) and the HMO or SSI HMO defines an emergency situation and includes general payment requirements.

Unless the HMO or SSI HMO has a written agreement with the non-network provider, the HMO or SSI HMO is only liable to the extent fee-for-service would be liable for an emergency situation, as defined in 42 C.F.R. § 438.114. Billing procedures for emergencies may vary depending on the HMO or SSI HMO. For specific billing instructions, non-network providers should always contact the enrollee's HMO or SSI HMO.

Topic #408

Non-Network Providers

Providers who do not have a contract with the enrollee's BadgerCare Plus HMO or Medicaid SSI HMO are referred to as non-network providers. (HMO and SSI HMO network providers agree to payment amounts and billing procedures in a contract with the HMO or SSI HMO.) Non-network providers are required to direct enrollees to HMO or SSI HMO network providers except in the following situations:

- When a non-network provider is treating an HMO or SSI HMO enrollee for an emergency medical condition as defined in the contract between the Wisconsin DHS (Department of Health Services) and the HMO or SSI HMO
- When the HMO or SSI HMO has authorized (in writing) an out-of-plan referral to a non-network provider
- When the service is not provided under the HMO's or SSI HMO's contract with the DHS (such as dental, chiropractic, and pharmacy services)

Non-network providers may not serve BadgerCare Plus HMO or Medicaid SSI HMO enrollees as private-pay patients.

Topic #409

Out-of-Area Care

BadgerCare Plus HMOs and Medicaid SSI HMOs may cover medically necessary care provided to enrollees when they travel outside the HMO's or SSI HMO's service area. The HMO or SSI HMO is required to authorize the services before the services are provided, except in cases of emergency. If the HMO or SSI HMO does not authorize the services, the enrollee may be held responsible for the cost of those services.

Topic #410

Provider Participation

Providers interested in participating in a BadgerCare Plus HMO or Medicaid SSI HMO or changing HMO or SSI HMO network affiliations should contact the HMO or SSI HMO for more information. Conditions and terms of participation in an HMO or SSI HMO are pursuant to specific contract agreements between HMOs or SSI HMOs and providers. An HMO or SSI HMO has the right to choose whether or not to contract with any provider but must provide access to Medicaid-covered, medically necessary services under the scope of their contract for enrolled members. Each HMO may have policies and procedures specific to their provider credentialing and contracting process that providers are required to meet prior to becoming an in-network provider for that HMO.

Topic #411

Referrals

Non-network providers may at times provide services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees on a referral basis. Non-network providers are always required to contact the enrollee's HMO or SSI HMO. Before services are provided, the non-network provider and the HMO or SSI HMO should discuss and agree upon billing procedures and fees for all referrals. Non-network providers and HMOs or SSI HMOs should document the details of any referral in writing before services are provided.

Billing procedures for out-of-plan referrals may vary depending on the HMO or SSI HMO. For specific billing instructions, non-network providers should always contact the enrollee's HMO or SSI HMO.

Topic #412

Services Not Provided by HMOs or SSI HMOs

If an enrollee's BadgerCare Plus HMO or Medicaid SSI HMO benefit package does not include a covered service, such as chiropractic or dental services, any Medicaid-enrolled provider may provide the service to the enrollee and submit claims to fee-for-service.

Covered and Noncovered Services

Topic #16197

Care4Kids Program Benefit Package

Covered Services

Members enrolled in the Care4Kids program are eligible to receive all medically necessary services covered under Wisconsin Medicaid; however, Care4Kids will have the flexibility to provide services in a manner that best meets the unique needs of children in out-of-home care, including streamlining PA (prior authorization) requirements and offering select services in home settings. Members will also be allowed to go to any Medicaid-enrolled provider for emergency medical services or family planning services.

Noncovered Services

The following services are not provided as covered benefits through the Care4Kids program, but can be reimbursed for eligible Medicaid members on a fee-for-service basis:

- Behavioral treatment
- Chiropractic services
- CRS (Community Recovery Services)
- CSP (Community Support Programs)
- CCS (Comprehensive Community Services)
- Crisis intervention services
- Directly observed therapy for individuals with tuberculosis
- MTM (Medication therapy management)
- NEMT (Non-emergency medical transportation) services
- Prescription and over-the-counter drugs and diabetic supplies dispensed by the pharmacy
- Physician-administered drugs and their administration, 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.

Topic #390

Covered Services

HMOs

HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements. Although ForwardHealth requires contracted HMOs and Medicaid SSI HMOs to provide all medically necessary covered services, the following services may be provided by BadgerCare Plus HMOs at their discretion:

- Dental
- Chiropractic

If the HMO does not include these services in their benefit package, the enrollee receives the services on a fee-for-service basis.

Topic #391

Noncovered Services

The following services are not covered by BadgerCare Plus HMOs or Medicaid SSI HMOs but are provided to members on a fee-for-service basis as long as ForwardHealth covers the service for the member, and the service is medically necessary:

- Behavioral treatment services (for example, autism services)
- Chiropractic services, unless the HMO elects to provide chiropractic services
- County-based mental health programs, including CCS (comprehensive community services), CRS (Community Recovery Services), CSP (community support program) benefits, and crisis intervention services
- Dental

  Note: HMOs must provide dental services in Milwaukee, Waukesha, Racine, Kenosha, Ozaukee, and Washington counties.

- Environmental lead investigation services provided through local health departments
- Hub and Spoke Health Home or SUD (substance use disorder) pilot programs (integrated recovery support services)
- Medication therapy management
- Pharmacy services and diabetic supplies
- PNCC (Prenatal care coordination) services
- Physician-administered drugs

  Note: The Physician-Administered Drugs Carve-Out Procedure Codes table indicates the status of procedure codes considered under the physician-administered drugs carve-out policy.

- Residential SUD treatment
- SBS (School-based services)
- Targeted case management services
- NEMT (Non-emergency medical transportation) services
- DOT (Directly observed therapy) and monitoring for TB (tuberculosis)-Only Services

Providers who render any of these services to a BadgerCare Plus or Medicaid SSI HMO member should submit PA (prior authorization) requests and claims directly to ForwardHealth for coverage.

Prior Authorization

Topic #400

Prior Authorization Procedures

BadgerCare Plus HMOs and Medicaid SSI HMOs may develop PA (prior authorization) guidelines that differ from fee-for-service guidelines. However, the application of such guidelines may not result in less coverage than fee-for-service. Contact the enrollee's HMO or SSI HMO for more information regarding PA procedures.

Claims

Topic #384

Appeals to BadgerCare Plus/Medicaid SSI HMOs and Children's Specialty Managed Care PIHPs

BadgerCare Plus/Medicaid SSI HMO and Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) contracted and non-contracted providers are required to first file an appeal directly with the HMO/PIHP after the initial payment denial or reduction. Providers should refer to their signed contract with the HMO/PIHP or the HMO's/PIHP's website for specific filing timelines and responsibilities (for example, PA (prior authorization), claim filing timelines, and coordination of benefits requirements) pertaining to filing a claim reconsideration and/or filing a formal appeal. The provider's signed contract with the HMO/PIHP may dictate the final decision. Filing a claim reconsideration is not the same as filing a formal appeal.

Appeal documents must reach the HMO/PIHP within the time frame established by the HMO/PIHP. Special care should be taken to ensure the documents reach the HMO/PIHP by the timely, filing deadline by allowing enough time for U.S. Postal Service mail handling or by using a verifiable delivery method (for example, secure Portal, fax, certified mail, or secure email).

The HMO/PIHP has 45 calendar days to respond in writing to a formal appeal. The HMO/PIHP decides whether to pay the claim and sends a letter stating this decision. If the HMO/PIHP does not respond in writing within 45 calendar days or the provider is dissatisfied with the HMO's/PIHP's response, the provider may submit an appeal to ForwardHealth through the Provider Appeals portal within 60 calendar days from the end of the 45 calendar day timeline or the date of the HMO/PIHP response.

Topic #385

Appeals to ForwardHealth

ForwardHealth **will not review** appeals that were not first made to the BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan). If a provider sends an appeal directly to ForwardHealth without first filing it with the HMO/PIHP, the appeal will be returned to the provider., and the payment denial or reduction will be upheld.

The provider has 60 calendar days to file an appeal with ForwardHealth after the HMO/PIHP either does not respond in writing within 45 calendar days, or if the provider is dissatisfied with the HMO/PIHP response.

Appeals will only be reviewed for enrollees who were eligible for and who were enrolled in an HMO/PIHP on the DOS (date of service) in question.

Once all pertinent information is received, ForwardHealth has 45 calendar days to make a final decision. The provider and the HMO/PIHP will be notified by ForwardHealth of the final decision. If the decision is in the provider's favor, the HMO/PIHP is required to pay the provider within 45 calendar days of the final decision. The decision is final, and all parties are required to abide by the decision.

Providers are required to submit an appeal to ForwardHealth through the Provider Appeals portal.

How to Begin Using the Provider Appeals Portal

Providers who contract with a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP and who need to appeal a claim decision will be required to register and set up a Provider Appeals portal account. Note: This portal account is separate from a provider's secure ForwardHealth Portal account.

To register for a Provider Appeals portal account, providers and HMOs/PIHPs can access the Provider Appeals portal. Providers are required to complete and submit the registration form, available by clicking either the HMO Registration or Provider Registration button (as applicable) on the Provider Appeals portal home page. Examples of information required to complete the registration process include the following:

- The provider's Medicaid ID or both their NPI (National Provider Identifier) and taxonomy code
- Provider zip+4 code
- DOS for the appeal
- Contact information (name, email, phone number) for the person registering

Once ForwardHealth receives and processes the registration form, an account login ID and associated PIN (provider identification number) will be created. Providers will receive an email message with their Provider Appeals portal login ID and will receive their PIN information in a mailed letter.

Note: Third party administrators and out-of-state providers must call the EDI (Electronic Data Interchange) Helpdesk at 866-417-4979 or send an email to vedswiedi@wisconsin.gov to begin registration.

More information on registering for and using the Provider Appeals portal and additional portal resources, including the Provider Appeals Portal User Guide, is available.

Portal Functionality

Providers can use the ForwardHealth appeals process through the Provider Appeals portal after exhausting the HMO/PIHP payment dispute process. Providers are required to use the Provider Appeals portal to:

- Submit an appeal to ForwardHealth for a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP claim payment denial or reduced payment.
- Submit documentation.
- Check the status of an appeal.
- Respond to requests for additional information.
- View decision notices.

For assistance regarding submission of an appeal through the ForwardHealth Portal, providers can call the ForwardHealth Managed Care Unit at 800-760-0001, option 1.

Required Documentation

When submitting an appeal to ForwardHealth through the Provider Appeals portal, the following documentation must be submitted/attached in required fields:

- The original claim submitted to the HMO/PIHP and all corrected claims submitted to the HMO/PIHP
- All of the HMO's/PIHP's payment denial remittances showing the dates of denial and reason codes with descriptions of the exact reasons for the claim denial
- The provider's written appeal to the HMO/PIHP
- The HMO's/PIHP's response to the appeal
- Relevant medical documentation for appeals regarding coding issues or emergency determination that supports the appeal (Providers should only submit relevant documentation that supports the appeal. Large medical records submitted with no indication of where supporting information is found will not be reviewed.)

- Any contract language that supports the provider's appeal with the exact language that supports overturning the payment denial indicated (Contract language submitted with no indication of where supporting information is found will not be reviewed, and the denial will be upheld.)
- Any other documentation that supports the appeal (for example, commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort)

Only relevant documentation should be included.

Appeal Decisions

A decision to uphold the HMO's/PIHP's original payment denial or to overturn the denial will be made based on the documentation submitted to ForwardHealth for review. Failure to submit the required documentation or submitting incomplete, insufficient, or illegible documentation may lead to the original denial being upheld. The decision to overturn an HMO's/PIHP's denial must be clearly supported by the documentation.

If the HMO/PIHP subsequently overturns their original denial and reprocesses and pays the claim for which an appeal has been submitted, providers must contact the ForwardHealth Managed Care Unit at 800-760-0001, option 1, and request that the appeal be withdrawn.

To check on the status of an appeal submitted to ForwardHealth, providers can:

- Access the Provider Appeals portal.
- Call the ForwardHealth Managed Care Unit at 800-760-0001, option 1.

Topic #386

Claims Submission

BadgerCare Plus/Medicaid SSI HMOs and Children's Specialty Managed Care PIHPs (Prepaid Inpatient Health Plans) have requirements for timely filing of claims, and providers are required to follow the HMO/PIHP claims submission guidelines for each organization. Providers should contact the enrollee's HMO/PIHP for organization-specific submission deadlines.

Topic #387

Extraordinary Claims

Extraordinary claims are BadgerCare Plus or Medicaid claims for a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) enrollee that have been denied by an HMO/PIHP but may be paid as fee-for-service claims.

The following are some examples of extraordinary claims situations:

- The enrollee was not enrolled in an HMO/PIHP at the time they were admitted to an inpatient hospital, but then they enrolled in an HMO/PIHP during the hospital stay. In this case, all claims related to the stay (including physician claims) should be submitted to fee-for-service. For the physician claims associated with the inpatient hospital stay, the provider is required to include the date of admittance and date of discharge in Item Number 18 of the paper 1500 Health Insurance Claim Form ((02/12)).
- The claims are for orthodontia/prosthodontia services that began before HMO/PIHP coverage. The provider must include a record with the claim indicating when the bands were placed.

Submitting Extraordinary Claims

When submitting an extraordinary claim, providers must include the following:

- A legible copy of the completed claim form in accordance with billing guidelines
- A letter detailing the problem, any claim denials, and any steps taken to correct the situation
- A copy of the Explanation of Medical Benefits form as applicable

Submit extraordinary claims to:

ForwardHealth
Extraordinary Claims
313 Blettner Blvd
Madison WI 53784

Topic #388

Medicaid as Payer of Last Resort

Wisconsin Medicaid is the payer of last resort for most covered services, even when a member is enrolled in a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan). Before submitting claims to HMOs/PIHPs, providers are required to submit claims to other health insurance sources. Providers should contact the enrollee's HMO/PIHP for more information about billing other health insurance sources.

Topic #389

Provider Appeals

When a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) denies a provider's claim, the HMO/PIHP is required to send the provider a notice informing them of the right to file an appeal.

An HMO/PIHP network or non-network provider may file an appeal to the HMO/PIHP when:

- A claim submitted to the HMO/PIHP is denied payment.
- The full amount of a submitted claim is not paid.

Providers are required to file an appeal with the HMO/PIHP **before** filing an appeal with ForwardHealth.